

UNITED STATES SENTENCING COMMISSION

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PUBLIC HEARING ON METHAMPHETAMINE

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TUESDAY
AUGUST 5, 2025

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The United States Sentencing Commission met in the Mecham Conference Center in the Thurgood Marshall Federal Judiciary Building, One Columbus Circle NE, Washington, D.C. at 9:00 a.m. EDT, the Honorable Carlton W. Reeves, Chair, presiding.

PRESENT:

CARLTON W. REEVES, Chair
LUIS FELIPE RESTREPO, Vice Chair
LAURA E. MATE, Vice Chair
CLAIRE MURRAY, Vice Chair
CANDICE C. WONG, Commissioner
SCOTT A.C. MEISLER, Ex-Officio Member

ALSO PRESENT:

KENNETH P. COHEN, Staff Director
KATHLEEN C. GRILLI, General Counsel

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

2 (9:03 a.m.)

3 CHAIR REEVES: I have the honor of opening
4 this hearing with my fellow commissioners. To my
5 left is Vice Chair Claire Murray. To her left is
6 Vice Chair Laura Mate, and to her left is our
7 Ex-officio, Scott Meisler. And to my right is Vice
8 Chair Luis Felipe Restrepo, and Ex-officio -- excuse
9 me, Commissioner Candice Wong.

10 We're also joined by commission employees
11 who do this work for us every day. Some of them
12 are in this room. Others are not. They have done
13 the research, and they have done an extraordinary
14 job of assembling these panels today. They've set
15 up this room, and they've done -- and they do so
16 much else every day. On behalf of the
17 Commissioners, ladies and gentlemen, and the
18 public, I want to thank all of our employees, our
19 staff, for the amazing work that they do every single
20 day.

21 When the Commission first created the
22 sentencing guidelines for meth offenses in the late

1 1980s, the average purity of meth sold in the United
2 States was rarely greater than 50 percent. At the
3 time, people trafficking highly pure meth were
4 higher up in the drug distribution chain and
5 therefore more culpable. In reflection of that
6 fact, the Commission followed Congress in creating
7 a penalty structure for meth that penalized sellers
8 of pure meth more heavily. This purity distinction
9 was meant to send a message that high-level
10 trafficking of meth does not pay.

11 Last year, the Commission released its
12 first comprehensive analysis of meth offenses in
13 nearly 25 years. It showed that meth trafficking
14 has changed in a number of ways since the Commission
15 adopted its purity-based meth guidelines. Meth
16 trafficking has increased across the country,
17 representing nearly 46 percent of drug-type
18 prosecuted last fiscal year. But meth is now
19 uniformly of high purity. Both high- and low-level
20 traffickers sell highly pure meth, and both get hit
21 with higher set of penalties.

22 Accordingly, meth traffickers are, on

1 average, sentenced significantly more severely than
2 traffickers of fentanyl, heroin, and cocaine. All
3 this raises a question of whether the purity
4 distinction is still sending the helpful message,
5 and if not, what will? Answering those questions
6 is why we are here today.

7 Of course, each commissioner and witness
8 speaking today has different views on the specifics
9 of sentencing policy, but we are all on the same
10 team. We all want to reduce the harm of meth
11 trafficking, and we all want to send a clear message
12 to high-level meth traffickers that what we are
13 doing is not right. What they are doing is not
14 right. Indeed, it is wrong, and it does not pay.

15 The purity distinction was meant to
16 achieve those goals, but if purity is no longer an
17 effective indicator of high-level trafficking, the
18 Commission needs to find out what is, so that we
19 can forge a better approach. Panelists, thank you
20 so much for all that you have been and for what you
21 have been willing to help us in in our search for
22 these answers. We have read your helpful written

1 submissions, which are already posted on our website
2 at www.ussc.gov.

3 Your time will begin when this light turns
4 green. You will have one minute left when it turns
5 yellow, and no time when it turns red. If I cut
6 you off, please understand I'm not being rude. I
7 just can't do that. And we have a lot to cover
8 today, and tomorrow we'll be working as well, so
9 we have a limited time to hear from everyone.

10 For our audio system to work, you will need
11 to speak closely into the microphones. When all
12 panelists have finished speaking, commissioners may
13 ask you questions. I'm certain they will. Thank
14 you, ladies and gentlemen, for joining us. I look
15 forward to a very productive hearing.

16 Our first panel that I need to introduce,
17 they're presenting the Federal Law Enforcement
18 perspectives on this issue. First, we'll be
19 hearing from Jonathan Fairbanks from the Drug
20 Enforcement Administration, the DEA, where he
21 serves as a supervisory special agent, as a group
22 supervisor over the Appalachian High-Intensity Drug

1 Trafficking Area.

2 Second, we'll hear from Scott Oulton, also
3 from the DEA, where he serves as Deputy Assistant
4 Administrator and Chief of Forensics in the Forensic
5 Science Division. Finally, we'll be hearing from
6 Dr. Buki Ebeigbe, also from the DEA, where she serves
7 as a pharmacologist in the Diversion Control
8 Program. Mr. Fairbanks, sir, we're ready to hear
9 from you.

10 MR. FAIRBANKS: Thank you. Chair Reeves
11 and members of the Sentencing Commission, on behalf
12 of the Drug Enforcement Administration, Louisville
13 Field Division, and the Appalachian High-Intensity
14 Drug Trafficking Area, thank you for this
15 opportunity to discuss methamphetamine trafficking
16 in the Appalachia region.

17 As a supervisory special agent, I
18 currently serve as the HIDTA Task Force Commander
19 for the Chattanooga Resident Office. HIDTA is a
20 program administered by the Office of National Drug
21 Control that aims to reduce drug production and
22 trafficking in critical regions through federal,

1 state, and local coordinated efforts.

2 I have served as a federal agent with DEA,
3 working in clandestine laboratory enforcement for
4 over 25 years. I have also served as the DEA Mexico
5 City Country Office Clandestine Laboratory
6 Coordinator, responsible for overseeing chemical
7 and clandestine laboratory investigations.
8 Additionally, I have served at DEA's training
9 academy as a course developer and instructor in
10 domestic and international clandestine laboratory
11 training teams.

12 I'm going to briefly discuss details about
13 methamphetamine, followed by testing and purity
14 points, and then finally trafficking patterns.

15 First, I will cover some basic background
16 information about methamphetamine.

17 Methamphetamine hydrochloride is a Schedule II
18 stimulant under the Controlled Substance Act due
19 to its high potential for abuse and danger. Its
20 illicit production processes also create toxic
21 environments that harm producers, first responders,
22 communities, and property owners.

1 Law enforcement officials or officers
2 typically encounter methamphetamine in five forms.

3 First, as a powder, often adulterated and of lower
4 purity, that is white or off-white in color,
5 typically snorted, injected, or taken orally.

6 Second, as base, which is a damp, oily substance
7 with a white, yellow, or brown color, often of higher
8 purity than powder, and is typically injected or
9 swallowed. Third, as high-purity crystalline,
10 known as ice, which is translucent to white,
11 crystal-like, and typically smoked or injected.

12 Fourth, in pill form, usually illicitly
13 produced counterfeit pills made with a stamp and
14 dye and pill presses, using unknown chemicals and
15 doses, making them extremely dangerous to ingest.

16 And fifth, as meth in liquid solution or liquid
17 meth, often used for easier transportation and
18 smuggling, and requires recrystallization prior to
19 consumption.

20 Second, I'll talk about the purity trends
21 we have observed. Following a drug seizure,
22 exhibits are transferred to a drug forensic

1 laboratory by law enforcement for confirmatory
2 analysis and substance determination following
3 specific protocols and policies. DEA uses their
4 own forensic laboratories, but other federal,
5 state, and local law enforcement agencies may use
6 their own or DEA's.

7 Field agents receive the results, which
8 include the identified substances, weight
9 submitted, substance purity when able, and the
10 amount of pure substance as identifiable. The bulk
11 of seized methamphetamine, both adulterated and
12 unadulterated, in the area of my task force's region
13 is consistently of a high purity of over 87 percent.

14 As an example, the purity of the drug exhibit seized
15 by the DEA Chattanooga Resident Office between July
16 2024 and July 2025 ranged between 78 percent to 98
17 percent, with an overall purity mean of 87.46
18 percent.

19 Experienced manufacturers, habitual
20 users, and trained law enforcement officers may be
21 able to distinguish highly pure methamphetamine
22 from lower purity methamphetamine that has been

1 heavily adulterated based on the drug's appearance,
2 color, texture, odor, and packaging, although the
3 recent adulteration of methamphetamine with other
4 list of substances like fentanyl make it very
5 difficult to identify and distinguish.

6 It is my experience, and throughout
7 criminal investigations, users of methamphetamine
8 are very particular with their product and often
9 seek the best high from a known product and source.

10 They do not like to buy products that do not closely
11 resemble the methamphetamine that they are
12 accustomed to getting. And we've seen that if the
13 product fails to result in the expected high, they
14 complain.

15 We hear them over wiretap investigations,
16 complain to their dealers about receiving bad meth,
17 lower purity, and insisting on getting a higher
18 purity product on the next buy. On occasion, some
19 of these confrontations become violent. The demand
20 for high purity meth in users has forced
21 transnational criminal organizations to improve
22 illicit production methods and manufacture a higher

1 purity of a product. The users' demand helps drive
2 the market for highly pure meth.

3 Third and finally, I'll discuss
4 methamphetamine trafficking patterns in the
5 Appalachian HIDTA region. The Appalachian region
6 consists of 91 counties across Tennessee, Kentucky,
7 West Virginia, and the western portion of Virginia.

8 In our region, methamphetamine is seized in various
9 forms, including crystalline meth or ice, powder,
10 pills, and then in liquid solution in that order.

11 The predominant form by volume is high purity
12 crystalline meth, referred to as ice, in the
13 Appalachian HIDTA's seizure data.

14 Ice remains the most trafficked and
15 preferred consumer form, showing year-over-year
16 increases and seizures of the drug have risen
17 sharply by approximately 190 percent compared to
18 2022 and 281 percent over the past two years compared
19 to levels prior to 2022. Ice is the predominant
20 form available.

21 In addition, DEA forensic laboratory data
22 from seized methamphetamine drug exhibits shows

1 significant increases in kilograms seized in the
2 last three years. At the current rate of 2025, we
3 will surpass 2024 could potentially exceed over
4 70,000 kilograms. The U.S. Customs and Border
5 Protection has seized 54,769 kilograms so far this
6 year. Last year they seized just over 79,000 kilos.

7 At this rate, CBP seizures will surpass 70,000
8 kilos again this year.

9 Seizure data from the Appalachian HIDTA,
10 DEA, and CBP indicate methamphetamine seizures in
11 2025 are on track to surpass previous years,
12 indicating a growing nationwide influx. Those
13 traffickers may use violence and intimidation to
14 maintain control over the trade and avoid detection.

15 DEA continues to see an increase in guns seized
16 as part of methamphetamine drug investigations.

17 Trafficking employs sophisticated
18 techniques, including encrypted communication and
19 complex smuggling methods to evade law enforcement
20 traffickers. And traffickers generally have ties
21 to both domestic and international organized crime
22 enterprises.

1 In regards to overdoses, methamphetamine
2 is a major danger and poses serious risks to users
3 and communities. CDC data shows fewer than 1,000
4 meth-related overdose deaths annually in the early
5 2000s, compared to a report of an estimated 37,000
6 in 2023. Another major driver is high-purity meth
7 mixed with fentanyl. As noted in my testimony,
8 domestic production and street sales endanger not
9 only users, but also first responders and law
10 enforcement.

11 In 2023, the state of Tennessee reported
12 1,500 overdose deaths from psychostimulants like
13 methamphetamine, followed by the years 2022 and 2021
14 with similar numbers, reflecting a rise since prior
15 years. In Hamilton County, with a population of
16 about 336,000, the overdose death rate is 23 per
17 100,000, alongside the 1,600 nonfatal overdoses in
18 2023. Methamphetamine poses severe risks, often
19 leading to death by stroke, heart attack, or organ
20 failure due to overheating.

21 Methamphetamine street prices and
22 seizures indicate the increased availability of

1 methamphetamine, specifically high-quality meth.

2 In 2007, one ounce of meth in Tennessee cost
3 approximately \$1,000 to \$1,800. But now the going
4 rate is approximately \$250 per ounce. This equates
5 to an average of \$3,500 per pound, of course, a
6 better price the more you buy, due to the high purity
7 levels. Street-level distributors have little
8 need to cut or add mixture due to cost resulting
9 in higher addiction and overdoses. Thank you again
10 for this opportunity to testify. I am happy to
11 answer your questions.

12 MR. OULTON: Good morning, Judge Reeves
13 and commissioners. Thank you for the opportunity
14 to discuss chemistry of methamphetamine, purity,
15 and DEA testing procedures. As DEA's Chief of
16 Forensics, I oversee ten decentralized and six
17 sub-regional laboratories with more than 560
18 employees that provide analytical, intelligence,
19 scientific, and other forensic and administrative
20 support to law enforcement, prosecutors,
21 legislators, and the public.

22 I began my career with the DEA as a forensic

1 chemist testing seized drugs in 1990. In my over
2 35-year career, I have participated in over 40
3 clandestine laboratory investigations involving
4 the manufacture of methamphetamine and have
5 testified in federal and state courts as an expert
6 scientific witness in over 125 criminal cases.

7 I'll focus my testimony today on three main
8 topics. First, the chemistry of methamphetamine
9 and how the forms differ. Second, how
10 methamphetamine and seize drugs is manufactured and
11 how the purity level now routinely exceeds 95
12 percent. And finally, how DEA standard testing
13 procedures require that seized methamphetamine be
14 tested for weight, identification, purity, and when
15 required, the D-isomer.

16 Turning first to chemistry of
17 methamphetamine. Methamphetamine exists in two
18 isomeric forms, D-methamphetamine and
19 L-methamphetamine. The chemical formulas are
20 exactly the same, but the arrangement of the atoms
21 differ. Like the left and right hand, they are
22 non-superimposable mirror images of each other.

1 That is what the structure looks like. The
2 difference matters in terms of effects on the body
3 and potency.

4 The D form is more sought after isomer for
5 production of illicit methamphetamine, which my
6 colleague, Dr. Ebeigbe, will discuss further. I'll
7 focus instead on the manufacturing and the purity
8 of methamphetamine.

9 When illicit methamphetamine production
10 became widespread in the 1980s, the preferred method
11 of manufacturing used a precursor called
12 Phenyl-2-propanol, also known as P2P, which
13 produced a 50-50 mixture of both types of
14 methamphetamine, commonly referred to as
15 DL-methamphetamine. At that time in the 1980s,
16 illicit drug manufacturers had no practical way of
17 separating the less stimulating L-methamphetamine
18 from the desired D-methamphetamine.

19 Then in the 1990s, illicit drug
20 manufacturers started using pseudoephedrine as a
21 precursor chemical to produce only the more potent
22 D-isomer. In the late 1980s and early 1990s, to

1 stem the spread of high-purity methamphetamine,
2 Congress established quantity thresholds for actual
3 methamphetamine, which refers to the amount of
4 quantity of the drug present relative to other
5 substances such as impurities, contaminants,
6 adulterants, and excipients. This change required
7 a purity test to determine the amount of pure
8 methamphetamine seized.

9 In doing so, Congress distinguished actual
10 or high-purity methamphetamine from mixture. In
11 response to a directive from Congress in the Crime
12 Control Act of 1990, the Commission added that the
13 category of ice to guidelines to its distinguished
14 methamphetamine with a very high purity. The
15 Commission defined ice as D-methamphetamine with
16 at least 80 percent purity.

17 This new category required additional
18 tests to determine the isomeric form of
19 methamphetamine. The sale of pseudoephedrine
20 products was restricted with the passage of the
21 Combat Methamphetamine Epidemic Act of 2005. These
22 restrictions, coupled with enforcement efforts,

1 prevented illicit manufacturers from readily
2 attaining the pseudoephedrine precursor. As a
3 result, illicit manufacturers reverted back to
4 chemicals like P2P, which makes a 50-50 mixture of
5 DL-methamphetamine.

6 However, in approximately 2007, illicit
7 manufacturers began deploying new chemical
8 techniques to convert DL-methamphetamine into the
9 more potent D-methamphetamine isomer. The process
10 of converting DL to D-isomer requires approximately
11 three to six more processing steps, but produces
12 the desired D-methamphetamine, the higher potency
13 that is currently trafficked today.

14 Today, we are seeing transnational
15 criminal organizations operating large-scale
16 laboratories, mostly in Mexico, capable of
17 producing overwhelmingly high-purity
18 D-methamphetamine on an industrial scale. As a
19 result, the purity of methamphetamine seized in
20 drugs now routinely exceeds 95 percent
21 D-methamphetamine. This is a significant increase
22 in purity since the 1990s, when the average purity

1 was 37 percent.

2 Methamphetamine is seized in three primary
3 forms, 91 percent as the crystalline powder, 8
4 percent as pills, and 1 percent as methamphetamine
5 contained within a liquid. The majority of seized
6 crystalline methamphetamine is of such high purity
7 that the total mixture is nearly equal to the actual
8 calculation.

9 More recently, drug cartels are producing
10 fake pills that visually mimic pharmaceutical
11 pills, drugs such as Adderall. Prescription
12 Adderall contains amphetamine. Instead, these
13 fake pills contain methamphetamine and other drugs
14 such as fentanyl. Of all the fake Adderall pills
15 that DEA receives, 96 percent contain
16 methamphetamine. Fake Adderall pills contain
17 approximately 5 percent methamphetamine.

18 While lower in purity, these fake pills
19 mimic the appearance of licit pharmaceuticals,
20 where the end user is likely unaware they are
21 consuming methamphetamine. DEA seizures typically
22 contain a large quantity of pills intended for

1 distribution.

2 The final topic I'll be covering is
3 chemical testing. DEA is accredited by the NACIE
4 National Accreditation Board and performs rigorous
5 chemical testing in conformance with ISO 17025.
6 When testing methamphetamine seizures, DEA's
7 testing policy is to determine the weight, identity,
8 purity, and when required, the isomer. Because
9 many state and local laboratories do not have the
10 methodology to determine purity and the isomeric
11 form of methamphetamine, DEA often gets requests
12 to resubmit those samples to DEA for further
13 testing.

14 Other federal agencies, such as Customs
15 and Border Protection, also have similar laboratory
16 systems and regularly conduct tests to determine
17 the weight, identity, and purity of methamphetamine
18 seizures.

19 Testing takes time and is costly. On
20 average, it takes four hours to identify the exhibit
21 as methamphetamine, an additional half an hour per
22 analysis to determine the isomeric form, and an

1 additional zero and a half an hour to determine the
2 purity for a total of one extra hour per exhibit
3 to do purity and isomer determinations.

4 To put this into perspective, DEA tests
5 approximately 16,000 methamphetamine exhibits per
6 year, which comprises approximately 30 percent of
7 our workload. Conducting purity and isomer testing
8 equates to 16,000 additional labor hours and costs
9 an additional 740,000 annually for equipment and
10 supplies.

11 In conclusion, I'd like to leave you with
12 three takeaways. DEA standard testing procedures
13 require that methamphetamine be tested for weight,
14 identification, purity, and required isomer.
15 Purity and isomer are time-consuming and costly.

16 Second, methamphetamine that traffickers are
17 supplying over the past decade is over 95 percent
18 pure in the form of the D-isomer.

19 And lastly, most methamphetamine is seized
20 in crystal and powder form. However, we are seeing
21 a steady increase in the large seizures of fake pills
22 containing methamphetamine. I appreciate the

1 opportunity to discuss the chemistry, purity, and
2 testing procedures for methamphetamine and look
3 forward to your questions.

4 CHAIR REEVES: Thank you. Dr. Ebeigbe.

5 DR. EBEIGBE: Good morning, Chair Reeves
6 and members of the Commission. My name is Dr. Buki
7 Ebeigbe, and I'm a pharmacologist with the Drug
8 Enforcement Administration. Over the past eight
9 years, I've worked in the drug and chemical
10 evaluation section of DEA's Diversion Control
11 Division, specializing in neuropsychopharmacology
12 and addiction science.

13 After earning my PhD in neuropharmacology
14 and completing a post-doctoral fellowship in
15 neuropsychopharmacology at Howard University's
16 College of Medicine, I served as a professor of
17 neuroscience, anatomy, and physiology at St. Mary's
18 College in Maryland before joining DEA.

19 In my current role, I assist in DEA's drug
20 scheduling efforts by authoring scientific reviews
21 published in the Federal Register to regulate novel
22 psychoactive substances. Additionally, I manage

1 research contracts to assess the abuse potential,
2 potency, and pharmacological effects of novel drugs
3 of abuse and provide expert witness testimony in
4 federal drug analog cases.

5 It is an honor to appear before you today
6 to discuss the pharmacology of methamphetamine,
7 including its mechanism of action and potency and
8 abuse potential, the clinical applications of
9 methamphetamine, and its implications for public
10 health and safety.

11 First, I'd like to share some background
12 on methamphetamine. Methamphetamine is a highly
13 addictive and potent central nervous system
14 stimulant. It's been abused in the U.S. since the
15 mid-20th century and is consumed in various ways,
16 including smoking, snorting, injecting, or oral
17 ingestion.

18 Methamphetamine produces intense
19 euphoria, elevated mood, and increased energy.
20 However, these effects come at a significant cost.
21 Chronic use is associated with severe adverse
22 effects, including insomnia, seizures,

1 cardiotoxicity, and long-term use can also result
2 in violent behavior, mood swings, paranoia, and
3 psychosis, including hallucinations and death.

4 Next, let's turn to the clinical
5 applications and the isomeric forms of
6 methamphetamine. Methamphetamine exists in two
7 isomeric forms, D-methamphetamine and
8 L-methamphetamine. The D-isomer is the more potent
9 form and is the active ingredient in the
10 prescription drug Desoxyn, which is used to treat
11 Attention Deficit Hyperactivity Disorder, and in
12 some cases, obesity.

13 Also because of its potency, the D-isomer
14 is the more common isomer used in illicitly produced
15 methamphetamine. The L-isomer on the other hand
16 is less potent and is found in the over-the-counter
17 nasal decongestants due to its vasoconstrictive
18 properties.

19 Regarding its mechanism of action,
20 methamphetamine exerts its effects by increasing
21 the levels of dopamine and norepinephrine in the
22 brain. These neurotransmitters are responsible

1 for the drug's stimulant effects, and
2 methamphetamine not only blocks the reuptake of
3 dopamine, as seen in the drugs like cocaine, but
4 it also reverses the dopamine transporter, leading
5 to a much higher accumulation of dopamine in the
6 brain. This mechanism explains the intense
7 euphoria and high abuse potential of
8 methamphetamine.

9 While both isomers of methamphetamine
10 increase neurotransmitters in the brain, their
11 effects on the neurotransmitter differ. The
12 D-isomer is a potent releaser of dopamine and
13 norepinephrine, making it highly addictive. In
14 contrast, the L-isomer primarily affects
15 norepinephrine and has minimal effects on dopamine,
16 which is why it's less likely to be abused.

17 So let's talk about the potency and the
18 abuse potential of methamphetamine. Potency is a
19 critical measure in pharmacology, referring to the
20 amount of drug needed to produce a desired effect.

21 D-methamphetamine is significantly more potent
22 than L-methamphetamine. Basically, this means

1 that it takes more of L-methamphetamine to produce
2 the same effect as D-methamphetamine.

3 Purity also plays a role in the drug's
4 effects. Pure methamphetamine contains only the
5 active drug, which is methamphetamine, while some
6 seized drug samples can contain other
7 pharmacologically active drugs like cocaine,
8 heroin, or fentanyl. These additional substances
9 can alter the overall effects of the drug, making
10 it difficult to predict the pharmacological
11 outcomes based on purity alone.

12 The last topic I'd like to discuss today
13 are the patterns of use of methamphetamine and its
14 public health impact. The method of administration
15 significantly influences the drug's effects.
16 Smoking or injecting methamphetamine delivers the
17 drug rapidly to the brain, producing an almost
18 immediate and intense high. Snorting and oral
19 ingestion result in slower absorption and less
20 intense effects.

21 Regardless of the method used to introduce
22 methamphetamine into the body, many national

1 surveys show that its abuse poses a severe risk to
2 public health. According to the Center for Disease
3 Control and Prevention, psychostimulants,
4 including methamphetamine, were involved in 31
5 percent of the drug-related deaths in 2023. Over
6 2.6 million Americans aged 12 or older reported
7 using methamphetamine in the past year, and
8 overdoses can result in hyperthermia,
9 cardiovascular collapse, and seizures.

10 Chronic use leads to tolerance, requiring
11 users to consume higher doses to achieve the same
12 effects, which increases the risk of overdose.
13 Long-term use is also associated with severe health
14 issues including insomnia, memory loss, and dental
15 abnormalities commonly referred to as meth mouth.

16 Finally, I'd like to emphasize three
17 points I hope are clear today. First,
18 methamphetamine is a powerful stimulant. It's
19 potentially dangerous and has a significant
20 potential for abuse. Second, the different isomers
21 of methamphetamine work pretty much the same in the
22 body. Third, while there are the over-the-counter

1 preparations that use L-methamphetamine in small
2 doses, these doses are not psychoactive. Drug
3 traffickers provide the potent D-methamphetamine
4 on the streets for users seeking its psychoactive
5 effects.

6 In conclusion, methamphetamine is a highly
7 potent and addictive drug that has devastating
8 effects on individuals and communities. The
9 D-isomer is primarily responsible for the drug's
10 stimulant effects and euphoric effects, while it
11 takes more of the L-isomer to produce the
12 pharmacological effects of the D-methamphetamine
13 isomer.

14 Methamphetamine's mechanism of action,
15 combined with its high potency and rapid onset of
16 effects, places it amongst some of the most commonly
17 abused drugs in the United States. As we continue
18 to address the methamphetamine crisis, it's
19 essential to consider the pharmacological nuances
20 of this drug to inform policy and sentencing
21 decisions. Thank you for the opportunity to share
22 my expertise, and I look forward to answering any

1 of your questions.

2 CHAIR REEVES: Thank you so much. You all
3 have set the standard high. A yellow light didn't
4 even come on. I turn to my commissioners. Any
5 questions for this illustrious panel? Judge
6 Restrepo.

7 VICE CHAIR RESTREPO: Yes. Special Agent
8 Fairbanks, thanks for being here. So given that
9 purity's gone up across the Board, what markers or
10 indicia would you suggest we take a look at to
11 identify folks in the hierarchy, so to speak, of
12 the distribution chain? Right now, everything's
13 tethered to the purity. In your experience, what
14 are more accurate markers, so to speak?

15 MR. FAIRBANKS: If I may, based upon the
16 street-level distribution, what we're seeing in our
17 region in southern Tennessee, the purity or the
18 high-quality meth is at a much lower distribution
19 level than it was in past years over my career.
20 There is little need to mix or add cut or to add
21 other substances to the methamphetamine that's
22 being distributed.

1 So in the traditional form of the
2 traffickers where you have the street sellers, they
3 have access to high-purity meth, as well as the
4 middle couriers or other traffickers at the higher
5 levels as they distribute it down amongst their
6 organization. I hope that answers your question.

7 VICE CHAIR RESTREPO: I guess my question
8 is, what should we look at to determine sentencing
9 policy in terms of markers tethered to culpability,
10 if not purity? How do I identify the folks that
11 we should be punishing more severely?

12 MR. FAIRBANKS: Well, from a case agent's
13 perspective, we present our cases to the
14 prosecutors. We provide the individual's
15 participation in the organization, in the drug
16 trafficking organization. Some of these
17 organizations or most are rather small, perhaps 10
18 to 20 individuals at the lower level, and they have
19 various roles and responsibilities. We help the
20 prosecutor define those roles based upon our
21 observations in the investigation and based upon
22 their roles and responsibility in selling is the

1 prosecutor would be one of those key individuals
2 to help us identify those charges.

3 VICE CHAIR RESTREPO: And how do we
4 quantify that in the guidelines?

5 MR. FAIRBANKS: I don't think I'm able to
6 answer that question in my position. Quantifying
7 the guidelines, we provide a lab report. We tell
8 the prosecutor how much product we have received.

9 VICE CHAIR RESTREPO: Maybe I'm not making
10 myself clear. So instead of purity, set purity
11 aside, how do I identify the folks that are more
12 culpable, so to speak, than less culpable? Is it
13 the role in the organization, the number of people
14 they supervise, the amount of money they make?

15 MR. FAIRBANKS: I think if I understand
16 your question clearly, there are -- let me respond
17 in this fashion. So there are financial managers
18 or organizers that run the money. There are
19 enforcers that use violence and intimidation in a
20 lot of these organizations. You have your
21 transporters or sellers. They could be one and the
22 same. And the term transporter is rather open to

1 discussion. And then it could be also the same as
2 distributors.

3 Then you also have producers and the
4 manufacturers that produce the product. And those
5 numbers have reduced themselves here in the US.
6 Based upon those roles and responsibilities, I know
7 the current federal sentencing or current statutes
8 under Title 21 define some of those roles.

9 VICE CHAIR RESTREPO: Thanks.

10 CHAIR REEVES: VC Murray, please go ahead.

11 VICE CHAIR MURRAY: Thanks so much to all
12 three of you for being here and for your testimony.

13 I know I read in at least Mr. Fairbank's and I think
14 several people's testimony that the number of guns
15 seized related to meth cases and the associated
16 non-drug crimes of theft, et cetera, is on the rise.

17 It's obviously interesting to see the
18 trend in it, but also interesting to see and to know
19 where it is relative to other drugs. Do you have
20 any experience -- I don't know how much you focus
21 on meth versus other drugs. What are you seeing
22 in terms of associated violence, associated

1 property crime, associated guns with meth cases
2 versus other drugs?

3 MR. FAIRBANKS: I'll answer first from our
4 observation. No matter what the illicit substance
5 is that's being distributed, guns always have a
6 play. In the Chattanooga, we have a significant
7 gang problem. Gangs and guns go hand in hand. Guns
8 help enforce their gang policies, if we use that
9 term, and their enforcement and their distribution.
10 They use the drug as a commodity to help increase
11 their strength in their organization.

12 But across the Board, whether it's being
13 methamphetamine or fentanyl distribution or cocaine
14 distribution, guns are one and the same. And the
15 number of guns we come across very frequently. So
16 I don't think -- there isn't a difference in product
17 of the volume of guns.

18 CHAIR REEVES: Commissioner Wong.

19 COMMISSIONER WONG: I understand from a
20 lot of this testimony that obviously purity has
21 clustered significantly or in terms of meth seizures
22 today than from years ago. But I wonder if in seeing

1 some of the testimony about how methamphetamine use
2 results in violent behavior, mood swings,
3 psychosis, is purity still a good proxy -- greater
4 purity still a good proxy for greater dangerousness?

5 Or are you seeing kind of less of a
6 correlation there because even lower purity meth
7 is more likely to be adulterated with fentanyl or
8 things like that, where now it's hard to draw kind
9 of a direct correlation between even if it was
10 between 80 percent purity versus 90 percent purity.

11 Are we still seeing that kind of linear correlation
12 or is it much more mixed?

13 MR. OULTON: I think I'll go ahead and
14 start. First off, in the '90s when it was 37
15 percent, we did see variations in purity during that
16 time and the potency of the different types of
17 isomers. Now, over the last decade, all we see is
18 virtually pure methamphetamine with the D-isomer.

19 So I don't believe there's any distinction left
20 in purity that is helpful. It's all the same in
21 essence.

22 COMMISSIONER WONG: Okay. And if I can

1 just follow up on that. Special Agent Fairbanks,
2 you talked about the predominance of ice in your
3 region. And I think from a guidelines perspective,
4 we have these three categories of meth, meth mixture
5 and ice. And there has been some criticism that
6 the term ice was not really a term of art prior to
7 the Commission's introduction of it. And I'm
8 wondering why is it that ice is predominated or
9 classification as ice as opposed to meth and meth
10 mixture, and whether you would see disruptive
11 effects from sort of moving to a more binary
12 classification between meth and meth mixture.

13 MR. FAIRBANKS: Thank you for the
14 question. As you heard from my colleagues,
15 methamphetamine is methamphetamine. The chemical
16 structure is the same. I am not a chemist, but I
17 taught the manufacturing processes. But with that
18 said, ice in the Appalachian HIDTA region is the
19 term that they will use on all of their
20 methamphetamine statistics reports. We submit a
21 quarterly seizure report to them and we report the
22 product and they tell us don't use meth, use the

1 term ice. So we write name ice in the column and
2 then the quantity seized and where it was seized
3 and the date.

4 In the DEA lab reports, we submit up to
5 the lab our exhibits and then they analyze that and
6 it comes back on their analysis report as
7 methamphetamine. So the term ice is a street term.

8 It was based upon its appearance, but based upon
9 its structure, it's methamphetamine.

10 COMMISSIONER WONG: Would you see any kind
11 of disruptive effects if you started using the term
12 methamphetamine instead of ice?

13 MR. FAIRBANKS: No, it's meth. And we
14 talk about it as meth and the term ice is in multiple
15 publications throughout and based upon its
16 appearance. But again, it's just methamphetamine.

17 And the purity levels have reached such a lower
18 level to the street to the users that it's
19 irrelevant.

20 COMMISSIONER WONG: Thank you.

21 CHAIR REEVES: Thank you. VC Mate,
22 please.

1 VICE CHAIR MATE: Thank you. I want to
2 echo the thanks to all of you for being here today
3 and for your thoughtful comments. We really
4 appreciate all the time and thought you put into
5 them. I think my first question is for you, Mr.
6 Oulton, just so I can -- making sure I understand
7 something you said today with the 16,000 labor hours
8 and I think I wrote down \$740,000. That's
9 attributable to testing for purity and isomers?

10 MR. OULTON: Correct, just -- yeah, I'm
11 sorry, finish.

12 VICE CHAIR MATE: Yeah, just it's for
13 those two kind of leaving the -- that's just for
14 those two pieces of that.

15 MR. OULTON: Yeah. To determine the
16 weight, the identity and everything else that we
17 do, that's about four hours per analysis. But to
18 do the additional isomer and purity testing, that
19 charges an additional hour on top of that. So total
20 of five hours. But so if you add up those 16,000
21 exhibits that we receive every year times 16,000
22 hours, it does take a lot of time. And it actually

1 equates to -- we would be capable of doing another
2 5,000 exhibits of analysis if we didn't do that type
3 of testing, for example.

4 VICE CHAIR MATE: Thank you, that's
5 helpful. And then, and please correct me if I'm
6 mischaracterizing from reading, it sounded to me
7 like when we're talking about potency as opposed
8 to purity, whether something is D-methamphetamine
9 or L-methamphetamine matters for that potency
10 question. And if so, is there any way to determine
11 potency without doing the isomeric testing?

12 MR. OULTON: Well, let me start first.
13 So there's a distinction between purity and potency.

14 So purity, for example, if I have 100 pounds of
15 methamphetamine and I determine that it's 95
16 percent, that means it's 95 percent pure
17 methamphetamine and five pounds of something else,
18 diluents, cuts, excipients, things along that lane.

19 When it comes to potency, I'm going to hand off
20 to my colleague over here because she is going to
21 be able to talk a lot more about potency.

22 DR. EBEIGBE: Right. So potency is more

1 defined by the amount of active ingredient in the
2 sample that gives a particular desired effect. So
3 a highly potent sample of methamphetamine would be
4 a sample that has mostly D-methamphetamine in it.

5 And the problem with potency and purity ideas is
6 that you could have some other adulterants in the
7 sample as well that diminish the potency of the
8 sample, right? So the more of the active ingredient
9 you have, that also causes the desired effect in
10 this case, right? The high the stimulant effect,
11 that is a more highly potent substance.

12 VICE CHAIR MATE: I think I get it. So
13 on the potency, so leaving purity aside and focusing
14 just on potency, if we were to try to test for --
15 not we personally, we would not be testing. But
16 if you were testing for potency, and maybe the answer
17 is that we can't just test for potency, it wouldn't
18 be potency of meth alone, or --

19 DR. EBEIGBE: So potency would be more of
20 a pharmacological testing, not necessarily a
21 chemical one. It could perhaps involve both. If
22 you're trying to identify first the substance, the

1 active substance, the ingredient, which in this case
2 would be D-meth, and then the effect of that
3 substance on the body or on an animal would have
4 to be tested as well.

5 MR. OULTON: If I could just add one thing
6 as an example. Fentanyl you see today, we have an
7 animal tranquilizer that they're adding to it called
8 Xylazine. And maybe adding the animal tranquilizer
9 to it actually prolongs and extends the effect of
10 the high. So that's what Dr. Ebeigbe is talking
11 about. Some of the other things that are mixed with
12 it could affect the overall potency.

13 VICE CHAIR MATE: Well, while I have the
14 mic, can I ask an unrelated question for Dr. Ebeigbe?

15 In your written testimony, I think you compared
16 methamphetamine to cocaine in terms of abuse
17 potential. And I was wondering, does that
18 comparison hold regardless of the, I'll switch back
19 to purity, purity of methamphetamine, or is it --

20 DR. EBEIGBE: That's a great question.
21 So if you're talking about a substance that -- a
22 sample that has more than methamphetamine in it,

1 let's say it has fentanyl, let's say it has maybe
2 Xylazine in it, that would definitely affect its
3 potency, right? And it's residual or resulting
4 effect on the body.

5 So if you're taking an adulterated sample
6 of methamphetamine and you're comparing it to
7 cocaine, the effects could vary. If you're taking
8 a pure sample of methamphetamine and comparing it
9 to cocaine, those are the effects that I write in
10 the testimony, right? That methamphetamine is more
11 potent than cocaine, et cetera.

12 VICE CHAIR MATE: Yeah, that's very
13 helpful. Thank you.

14 DR. EBEIGBE: You're welcome.

15 VICE CHAIR RESTREPO: Yes, this is a
16 question for the DEA folks. So if purity is not
17 really the best point of reference in terms of
18 sentencing outcomes, what other factors should we
19 take into consideration to better inform sentencing
20 outcomes? Either Dr. Ebeigbe or Mr. Oulton or both?

21 DR. EBEIGBE: So unfortunately, I think
22 this is kind of out of our -- at least my wheelhouse.

1 I think what I can say is, if you -- I can tell
2 you what you should not do.

3 VICE CHAIR RESTREPO: That's okay.

4 DR. EBEIGBE: Okay. I think that
5 distinguishing between the isomers is not workable.

6 I wouldn't do that, primarily because the
7 D-methamphetamine isomer and the L kind of have
8 similar effects in the body, albeit D being much
9 more potent, much more powerful. So in that way,
10 I would answer the question. I don't know that I
11 can answer it more directly.

12 VICE CHAIR RESTREPO: Very helpful, thank
13 you.

14 DR. EBEIGBE: Okay.

15 VICE CHAIR RESTREPO: Same question, Mr.
16 Oulton.

17 MR. OULTON: Well, first off, I agree.
18 Doing the isomer testing is costly and does take
19 time and it doesn't seem to affect the outcome or
20 the sentencing. And I can't opine beyond that,
21 other than the other drugs that we analyze, for
22 example, cocaine, heroin, and fentanyl, for

1 example, there's no purity distinctions for those
2 either. So I don't know how you get around figuring
3 out which ones are the higher penalties, but same
4 type of drug, same type of concept.

5 VICE CHAIR RESTREPO: Thank you very much.

6 CHAIR REEVES: Yeah, no, go ahead. Go
7 ahead, VC Murry.

8 VICE CHAIR MURRAY: I know none of you is
9 a prosecutor, but I'm hoping you might have
10 visibility on something that has been confusing to
11 me the whole time. So if almost all crystal meth
12 is 95 percent, 98 percent pure, why are there some
13 jurisdictions where that is primarily charged or
14 sentenced as ice, which for purposes of the
15 guidelines is something 80 percent or higher pure,
16 and in other jurisdictions, it's predominantly
17 charged and sentenced as meth actual?

18 MR. FAIRBANKS: Let me start with my
19 observations. So in Tennessee, methamphetamine is
20 the largest drug being distributed in the state.

21 In our area, the Eastern District of Tennessee is
22 for the US Attorney's Office there, they use

1 conspiracy charge and other charges in lieu of the
2 sentencing guidelines. They'll use the mixture
3 charge if it includes fentanyl or substances similar
4 to that.

5 But traditionally, they don't have a
6 practice of using the enhancement for ice because
7 of the other charges and based upon the math, and
8 I'm not great at the categories of quantity, but
9 they want to know how much was it and is it meth?

10 That's what they want to know first of. And at
11 the state level and counties, is it meth, first
12 question, second is how much, and that's what they
13 use for charging in the state.

14 VICE CHAIR MURRAY: So no purity?

15 MR. FAIRBANKS: Purity comes into play,
16 yes, from the lab results, and Mr. Oulton can explain
17 this in more detail, but the DEA labs had a backlog
18 over the past several years and they've caught up
19 on this significantly. So we as a case agent, we
20 would receive the purity results later in the
21 prosecutorial phase, and then they would come up.

22 But by that point, charges had already been placed

1 on the indictments, which conspiracy or trafficking
2 or other such charges.

3 VICE CHAIR MURRAY: So maybe it's the
4 sentencing phase that they're deciding whether or
5 not to treat it as ice or as meth actually, because
6 anything over 80 percent, you could calculate either
7 way. Do you have any --

8 MR. FAIRBANKS: I believe you're correct,
9 I haven't prosecuted a case or presented a case to
10 a prosecutor myself in the last six years, but my
11 case agents in my office do so weekly. And we'll
12 get the quantity first, and then later when the lab
13 results come back, we'll provide that into the case
14 file at discovery, and then the purity comes
15 available then. But yes, I think it's safe to say
16 in the sentencing portions of that, or if trial is
17 pending months down the road, it comes into play.

18 MR. OULTON: And if I may add to that, so
19 as Special Agent Fairbanks was discussing,
20 approximately three years ago, we had a 42,000
21 exhibit backlog, 42,000 exhibits waiting to be
22 tested. And we receive on average about 5,000 per

1 month and we're capable of analyzing 5,000. So you
2 see the conundrum we were in.

3 So what was happening is our US attorneys
4 were waiting nine months to get a result. So they,
5 I can't presume to know what they do, but they were
6 prosecuting their cases the best they had without
7 the information that they needed. So we have
8 significantly reduced our backlog, so now we're
9 doing testing in about 30 days, which is -- we still
10 want to go faster because we want to give our
11 prosecutors the information they need to charge
12 however they think it's possible.

13 The distinction between ice and actual,
14 as we talked about, it essentially results in the
15 same base offense level because all of our
16 methamphetamine that we seize is greater than 95
17 percent. So it automatically qualifies as ice.
18 It's greater than 80. So our US attorneys, majority
19 of the ones that we've been working with have been
20 charging solely based on actual and not requiring
21 the ice because it results in the same base offense
22 level, if that's helpful.

1 VICE CHAIR MURRAY: We have kind of a map
2 that they've shown us of jurisdictions where the
3 primary way that things are sentenced is mixture,
4 which is the places basically where there's no
5 testing, right? Where there's -- and then places
6 where it's primarily sentenced as ice and places
7 where it's primarily sentenced as actual. And
8 there are many jurisdictions where it's primarily
9 sentenced as actual, but actually there are more
10 jurisdictions than you would think where it's
11 primarily sentenced as ice, and that's curious to
12 me.

13 MR. OULTON: In some instances, for
14 example, our Customs and Border Protection, they
15 have a laboratory system very similar to ours and
16 they're right on the Southwest border. So they have
17 laboratories and they do purity determinations and
18 isomer determinations. We, by normal course of
19 asking our United States attorneys, if you want us
20 to do the isomer test, we will. So we've kind of,
21 in some sense, backed off of doing the isomer
22 testing. So in those instances, they can own, they

1 don't have enough information to charge ice. But
2 in other jurisdictions, we do the isomer testing,
3 and then they'll pursue that charge.

4 CHAIR REEVES: Commissioner Wong.

5 COMMISSIONER WONG: In terms of
6 importation of methamphetamine on the ground, are
7 you seeing a predominant or primary form of how --
8 what's the factual scenario we're seeing most
9 commonly?

10 MR. FAIRBANKS: I refer in my statement,
11 I can start with that. We are seeing it come across
12 in meth and liquid solution for easier concealment
13 and transportability into the U.S. It's also
14 coming across in kilo bricks through various ports
15 of entries. The volume is increasing. And I think
16 the CBP seizure data would be able, if we were to
17 dig deeper into that, would be able to provide a
18 more clear answer as to which form is the most
19 commonly seized. But from us in the Appalachian
20 region and in Tennessee, it's in crystalline form.

21 CHAIR REEVES: Mr. Oulton, I have a
22 question, and then I think I might have one for Dr.

1 Ebeigbe. With respect to the area, is there any
2 particular -- are you doing drug testing nationally
3 or in a particular area?

4 MR. OULTON: We have laboratories
5 throughout the United States. So all the data that
6 I'm presenting is based on DEA testing from all
7 throughout the United States, ten laboratories.

8 CHAIR REEVES: Okay. From all ten
9 laboratories?

10 MR. OULTON: Yes.

11 CHAIR REEVES: And I guess these 5,000 a
12 month or whatever the exhibits that you're able to
13 handle, those that are waiting in line, I'm assuming
14 defendants are waiting to be prosecuted based on
15 the findings that you are to make, is that right?

16 MR. OULTON: It's certainly during that
17 period of time when we were a nine month backlog,
18 we were waiting for US attorneys to call us up and
19 beg us to analyze the exhibit so they could prosecute
20 their cases. So I can't answer beyond that other
21 than we were doing the best we could with the
22 resources that we had.

1 CHAIR REEVES: Right. And I only ask that
2 question because many of these defendants remain
3 in pretrial detention during the course of waiting
4 for their trial. And of course, that's an expense
5 as borne by the U.S. Marshals Service, I guess,
6 because those pretrial detainees are in the custody
7 of the United States Marshals for that extra period
8 of time awaiting for trial. Because we've written
9 our laws that there's a presumption that those
10 people remain detained until their trial.

11 So the added cost is in addition to the
12 16,000, I think you said 16,000 hours, plus the six
13 hours for each test that it takes to do, five or
14 six hours for each test. Is that right?

15 MR. OULTON: That's correct.
16 Approximately five hours.

17 CHAIR REEVES: All right. Now, Dr.
18 Ebeigbe, I want to make sure I understand with you.
19 I think in your written testimony, you used the
20 term that is the peer-to-base distinction. There's
21 no pharmacology. I hope I'm saying the word right.
22 Pharmacological, say it for me.

1 DR. EBEIGBE: Pharmacological?

2 CHAIR REEVES: There you go,
3 pharmacological.

4 DR. EBEIGBE: Okay. There we go.

5 CHAIR REEVES: That there's no pertinent
6 difference. Could you just explain that for me?
7 Because I couldn't say the word.

8 DR. EBEIGBE: Sure. I think your
9 question is, are you asking about the purity itself
10 and how that is devised in pharmacology? Like how
11 do we know --

12 CHAIR REEVES: Yes.

13 DR. EBEIGBE: How are we defining -- okay.

14 So typically, we're defining purity as the amount
15 of active ingredient in the sample. But in many
16 cases in this, I mean, poly-drug use era and the
17 era in which there's a lot of adulterants in the
18 samples, there are other active ingredients that
19 are not intended, that the user doesn't know is in
20 there, right? So then in this case, we could have
21 methamphetamine and then we could have fentanyl.

22 We can have a little bit of Xylazine, all in the

1 same sample, even though it may be predominantly
2 methamphetamine.

3 So purity, the distinction for us, for
4 pharmacologists, is really like the amount of active
5 ingredient that is intended to be there, right?
6 And so in this case, it would be methamphetamine.

7 Does that make sense?

8 CHAIR REEVES: What, if any difference it
9 is -- I mean, you know, street level users just sell
10 it to whomever.

11 DR. EBEIGBE: Yes.

12 CHAIR REEVES: Whoever will buy it, they
13 will buy it. What about a person's physiological
14 body might make a distinction between how it affects
15 individuals based on whether it's cut with BC
16 powder, I'm just saying, or with cocaine or with
17 fentanyl or with anything else, Xylazine, what you
18 mentioned. What if it's adulterated or cut with
19 any other thing? Does a person's physiological
20 makeup have any difference or any bearing on how
21 it affects that individual?

22 DR. EBEIGBE: Sure, I think it takes into

1 consideration a couple of things. If that person
2 is a user of any of the other substances in that
3 sample. So let's say it's cut with Xylazine. I
4 prefer it's adulterated with Xylazine, right? I
5 mean, tolerance to the other substances in the
6 sample would dictate perhaps how it affects that
7 particular user.

8 You know, there's other things, the
9 bioavailability, how those -- bioavailability is
10 kind of a pharmacological term, but it just means
11 how available the drug is once it's ingested.
12 Because the body does a bunch of different things
13 to drugs in order to allow it to be present in the
14 bloodstream. So any amount of the drug that's in
15 the bloodstream is free to interact with the brain
16 and go in and have its effects.

17 So things that could affect that would be
18 a tolerance to a particular -- that could affect
19 the body's effects, right? The body's resulting
20 effects after taking the drug. It could be things
21 like tolerance, the method in which the person took
22 the drug. So, snorting or smoking, injecting, et

1 cetera, different -- there are different things that
2 could affect that, yes.

3 CHAIR REEVES: Okay. Thank you.

4 DR. EBEIGBE: Sure.

5 CHAIR REEVES: Thank you, lady and
6 gentlemen, for your testimony. We certainly
7 appreciate it and thank you so very much.

8 DR. EBEIGBE: You're welcome.

9 CHAIR REEVES: We're ready for our second
10 panel as we swap out places. And obviously you're
11 free to stay around to listen to the other testimony
12 if you wish.

13 (Whereupon, the above-entitled matter
14 went off the record at 10:03 a.m. and resumed at
15 10:04 a.m.)

16 CHAIR REEVES: The panel will provide us
17 with perspectives from academic experts. First,
18 we have Dr. Karla Wagner. I presume it's Wagner,
19 not Wagner. All right, okay. A behavioral
20 scientist and professor in the School of Public
21 Health at the University of Nevada, Reno.

22 Second, we have Dr. Jonathan Caulkins who

1 serves as a Stever University professor of
2 Operations, Research, and Public Policy at Carnegie
3 Mellon University's Heinz College and as a member
4 of the National Academy of Engineering. Dr.
5 Wagner, we're ready when you are.

6 DR. WAGNER: Thank you. Thank you, Chair
7 Reeves and everybody on the commission for the
8 invitation to be here today. I really appreciate
9 the opportunity to get to share some of my research
10 on methamphetamine to more of these deliberations.

11 I'm a behavioral scientist. I work in a
12 school of public health. And since 2014, I have
13 been living and working in Nevada, where the
14 prevalence of methamphetamine use and related harms
15 are extremely high.

16 The age-adjusted death rate for
17 methamphetamine-involved deaths in Nevada is 18 per
18 100,000, compared to the U.S. average of 11 per
19 100,000. So as a result, I have focused a
20 significant portion of my research agenda on this
21 issue.

22 This morning, I'm going to share

1 information that I have learned directly from people
2 who use methamphetamine. They are the ones with
3 the most firsthand knowledge of what's going on in
4 the streets, what the health consequences are, and
5 what prevention and treatment strategies are most
6 effective.

7 This information has been gathered by me,
8 by my staff, and by my students, who spend many,
9 many hours sitting in rooms with people who use
10 methamphetamine and talking with them about their
11 lives. We just wrapped up a study in which we did
12 one-on-one interviews with 420 people who use
13 methamphetamine in Nevada and New Mexico.

14 So just to sort of cut to the chase, in
15 response to the first question of whether the
16 existing sentencing disparities are warranted, my
17 professional opinion is no, they're not. My
18 research supports the Commission's own findings
19 that today's methamphetamine is highly pure with
20 few contaminants.

21 We analyzed street drug samples from 25
22 states, and so these are samples that are submitted

1 to a lab by people who use drugs. And we found that
2 the average number of substances detected in crystal
3 methamphetamine was just one. We only found
4 methamphetamine.

5 This tells us that the methamphetamine
6 contains very few adulterants, even fentanyl. In
7 fact, our final analysis reported that fentanyl was
8 detected in only 6% of those methamphetamine
9 samples, and in many cases, that appeared to be due
10 to cross-contamination, so inadvertent
11 mishandling.

12 So given the nearly universal availability of
13 high-purity methamphetamine, the distinction
14 between methamphetamine actual, or ice, and
15 methamphetamine mixture doesn't make sense to
16 people using drugs in this landscape. People are
17 not choosing their drugs based on purity.

18 Everything available to them is very pure,
19 and it is my opinion that most people are responding
20 to the market, not driving it. So now turning to
21 the current threshold of five grams, which we
22 haven't talked about yet this morning, five grams

1 of methamphetamine actual, or ice.

2 So I talked to people in preparation for
3 this conversation to learn about what they are using
4 and purchasing on a regular basis, and what I learned
5 is that five grams is not a lot of methamphetamine.

6 Average users who inject might consume one gram
7 over one to three days. Average users who smoke
8 might consume as much as 3.5 grams per day.

9 So based on this information, five grams
10 could easily represent just one or two days of
11 personal use for someone who smokes, and maybe a
12 week or two for someone who injects. And as I
13 mentioned in my written statement, there are many
14 reasons why people might have even more than this
15 and still not be involved in trafficking.

16 I also learned that the methamphetamine
17 is really cheap right now. Just this month when I
18 was asking people what they're paying on the street,
19 the prices for crystal methamphetamine where I work
20 ranged from 10 to \$20 a gram, with prices varying
21 based on location and quantity.

22 And buying in bulk is cost-effective. For

1 instance, one participant in my study told me that
2 he can buy seven grams for \$50. This is about half
3 of what he would pay if he bought those grams
4 individually.

5 So the conclusions that we can draw from
6 this is right now methamphetamine is very cheap and
7 very pure. Five grams is clearly too low of a
8 threshold to determine trafficking, and it's easy
9 to see how someone with even as little as \$50 could
10 have much more than this in their possession.

11 I'd like to now turn my attention to the
12 reasons that people use methamphetamine and the
13 health consequences. My research shows that people
14 who use methamphetamine for reasons that many of
15 us would agree are quite rational, especially when
16 you live in a world where illegal drugs are easier
17 to access than more appropriate healthcare and
18 clinical options.

19 In that study of 420 people that we
20 interviewed in Nevada and New Mexico, 61% said they
21 used methamphetamine to help them stop worrying,
22 and 69% said they use it to feel better when they're

1 depressed. They're using methamphetamine to
2 self-medicate their mental health concerns.

3 Three-quarters of the people in that study
4 said they use it to stay awake. More than half said
5 they use it to help concentrate or study or work,
6 and nearly half said they use it to relieve physical
7 pain, that they can't get treated with more
8 appropriate treatments.

9 In our qualitative work, participants
10 report using methamphetamine to alleviate the
11 over-sedation of fentanyl or other opioids,
12 including the methadone that they're prescribed for
13 the treatment of their opioid use disorder.

14 We're having a lot of conversations right
15 now about increases in drug overdose deaths
16 involving methamphetamine, and this has been a
17 really important catalyst for some of the work in
18 my group. We asked people who use methamphetamine
19 directly if they've ever experienced a
20 methamphetamine overdose, and they definitively
21 tell us this is not possible.

22 People don't die from meth. They look at

1 me like I don't know what I'm talking about. They
2 do describe acute and often worrisome symptoms that
3 generally fall into two categories; cardiovascular
4 harms, things like rapid heart rate, difficulty
5 breathing, and psychiatric harms, anxiety,
6 paranoia, hallucinations.

7 But given what we know about the mechanics
8 of acute methamphetamine toxicity compared to
9 opioid overdose, it really doesn't make sense to
10 be calling these deaths methamphetamine overdose
11 deaths.

12 If we look closely at the overdose death
13 surveillance data, we see that a large share of the
14 deaths involve multiple drugs, including stimulants
15 and opioids. And this tracks with my research.

16 In that study of 420 people, over 90%
17 reported using multiple drugs. The average number
18 of illicit drugs that people reported was three.

19 If we include also alcohol, tobacco, and nicotine,
20 the average number was six.

21 Only a handful of people in that study,
22 and we recruited people who use methamphetamine --

1 only a handful of people use only methamphetamine.

2 In another study, I analyzed data from 168 deaths
3 with a positive toxicology report in Nevada, so
4 people who died with drugs on board. Just one
5 quarter of them involved stimulants alone.

6 Three quarters involved opioids and
7 stimulants. We found that people whose death was
8 attributable to stimulants alone were on average
9 more than 10 years older and had a higher prevalence
10 of cardiovascular disease and diabetes compared to
11 people who died with only opioids or opioids and
12 stimulants.

13 So these data suggest that stimulant-only
14 decedents are older and sicker than opioid
15 decedents. And it points to an accumulation of
16 chronic disease over years of methamphetamine use.

17
18 In fact, a recent analysis of
19 methamphetamine-involved deaths in San Francisco
20 found that stimulant-only deaths were less likely
21 to have any evidence of recent drug use compared
22 to stimulant-fentanyl deaths.

1 The researchers concluded that many of
2 these deaths might not be driven by acute toxicity
3 at all, but instead the result of chronic disease
4 contributed to by years of substance use.

5 I'm not saying that methamphetamine is
6 harmless. We know that methamphetamine use is
7 associated with infectious disease transmission,
8 neurological changes, damage to the cardiovascular
9 and the cerebrovascular system, heart failure and
10 cardiac disease are commonly identified as the cause
11 of death among people who use methamphetamine.

12 So I want to talk lastly about the ways
13 that people who use methamphetamine try to keep
14 themselves safe, and I think this is relevant to
15 today's conversation.

16 People who use drugs are well aware of the
17 harms, and they do a lot to try to minimize those
18 harms. And a lot of it right now is all tangled
19 up with fentanyl. It's important to note that most
20 people, as I said, are poly-drug users, and many
21 people use both methamphetamine and fentanyl.

22 And in response to the increased

1 availability and lethality of fentanyl, many people
2 have switched from injecting to smoking their drugs.

3 This helps them avoid HIV and hepatitis C virus
4 infection. It also helps them regulate their dose
5 so that they don't overdose on fentanyl.

6 And one of the primary ways that people
7 who use methamphetamine tell us that they try to
8 stay safe in this very volatile market is to buy
9 their drugs from a trusted source. They rely on
10 this more strongly than using fentanyl test strips
11 or other prevention methods.

12 And you can see how activities that disrupt
13 street-level selling, low-level selling, and buying
14 networks can easily interfere with this strategy
15 and expose people to different and unknown products.

16 Low-level sellers are easily replaced, so
17 taking one person out only disrupts that network,
18 but it doesn't address the source. From a public
19 health perspective, what we think we need to do is
20 address root causes. If we want people to change
21 their behavior, the threat of incarceration does
22 not do that.

1 I know somebody who's been arrested 14
2 times, and he just graduated from treatment for the
3 ninth time, and he attributes that successful
4 treatment graduation and the change in his drug use
5 not to the threat of penalties, but to the
6 investments that a community of people made in him.

7
8 Now he works for me, has a full-time job
9 with benefits, and is going back to school. The
10 answer from a public health perspective is to invest
11 in the evidence-based solutions that help people
12 get their basic needs met, their trauma and
13 behavioral health care needs addressed, and to
14 invest heavily in expanding access to
15 evidence-based treatment and research to expand the
16 availability of that treatment.

17 Thank you for the opportunity to share
18 these thoughts.

19 CHAIR REEVES: Thank you, Dr. Wagner.
20 Dr. Caulkins, please.

21 DR. CAULKINS: Good morning, Chair Reeves
22 and commissioners. Thank you so much for the chance

1 to present here. I've been studying drug policy
2 for a little over 35 years, and my specialty is the
3 logistics and supply chains of illegal markets.

4 I'm going to try to make five points. The
5 first is that it does happen at times in some
6 countries and markets that an illegal drug appears
7 in what amount to qualitatively two different forms,
8 one more harmful than the other. And I use as an
9 example in the written testimony, Denmark and
10 cocaine.

11 Who would have known? But from roughly
12 2012 to 2016, it turned out that Denmark had both
13 low purity cocaine, usually around 20%, and high
14 purity cocaine, usually around 80%, not much in
15 between.

16 So in that country, in that market for that
17 drug, there would be at least a possible
18 justification for having two different schedules
19 for the same total weight of the low purity and the
20 high purity cocaine.

21 I mention that to point out that it's not
22 an intrinsic property of the chemistry of the drug,

1 or its psychopharmacological properties, because
2 cocaine powder has never looked like that in the
3 United States.

4 Whether or not a drug appears in two or
5 more sort of qualitatively different forms is in
6 some measure just the collective decisions of the
7 drug traffickers who are doing the supplying. In
8 the United States today, cocaine doesn't look like
9 that, meth doesn't look like that.

10 The only major drug in the United States
11 that does look like that is fentanyl, which appears
12 in fentanyl powder. Lot of variety in the purity,
13 but 10 to 20% might be typical. And counterfeit
14 pills, which are typically two milligrams in a
15 roughly 120 milligram tablet, were about 2%, so
16 there's sort of a five to 10 difference there.

17 But cocaine and methamphetamine are not
18 like that today. As other people have already said,
19 in the past, meth was different. In the past,
20 purity declined as it moved down the distribution
21 chain, so high purity was correlated with market
22 level and culpability, but that's not true anymore.

1 In the past, there was sold commonly both
2 the racemic mixture that was some D and some L, or
3 also stuff that was mostly D. But today, it's
4 almost all D form. So no longer in the U.S. today
5 are there commonly sold these qualitatively
6 different forms that might justify having different
7 schedules.

8 And as a result, having different
9 schedules in a market that is essentially selling
10 just one kind of product creates the opportunity
11 for arbitrary decisions about how something is going
12 to be charged.

13 If there's a kilogram that's 95% pure, it
14 could be charged as one kilogram of mixture, or it
15 could be charged as 950 grams actual, which of course
16 is equivalent to 9.5 kilograms of mixture in the
17 sentencing table.

18 So there's sort of an arbitrary decision
19 that determines whether or not that defendant gets
20 charged here or gets charged at a level that would
21 be akin to their supplier who is dealing in
22 quantities 10 times as much.

1 So that's the first half of what I'd like
2 to say, that no longer does it make sense to
3 distinguish, but then that raises the question of,
4 should mixture be charged the way ice and actual
5 are today, or should ice and actual be charged the
6 way mixture is today? And I make three arguments
7 in the written testimony for why it would make sense
8 to go the latter.

9 The first is to look at the number of
10 chronic users who are supported per kilogram of
11 material for meth and for cocaine. It could go in
12 the Q&A why the term is chronic user, it came from
13 ONDCP, there's pros and cons, but the idea is how
14 many of the people that Dr. Wagner was talking about
15 are supported per kilogram of material, meth or
16 cocaine?

17 And the short answer is for the year, most
18 recent year for which we have good data was about
19 the same. The second comparison is to think about
20 the value to the traffickers, because when you are
21 supplying drugs, you're doing two kinds of harm that
22 generate two sources of your culpability.

1 One is you're supplying the drug that's
2 harmful to the users. The other is you're
3 participating in illegal market whose profits
4 generate incentives for violence, corruption,
5 distort labor markets, and all of the problems that
6 come with large illegal markets.

7 And now that methamphetamine prices have
8 gone down so much, that economic value per kilogram
9 is lower for methamphetamine than it is for cocaine
10 on a weight for weight basis.

11 So the person who's responsible for
12 trafficking a certain quantity of methamphetamine
13 is responsible for fewer dollars in the market, less
14 incentives for violence, than a person trafficking
15 the same quantity of cocaine.

16 The third set of arguments come from a
17 draft paper done with my colleagues, Greg Maget
18 (phonetic) and Peter Reuter. We look at four
19 separate harms to users and to society more
20 generally, death, emergency remissions, chronic use
21 and adult male arrestees per unit weight.

22 Again, sentencing guidelines focus on

1 weight. So we look at it per unit weight for crack
2 and for methamphetamine mixture. And in
3 particular, the key table looks at 28 grams of crack
4 and five grams of meth mixture, which would be
5 charged the same way if we collapse from actual and
6 ice coming down to being like mixture.

7 On all four of those outcomes, the 28 grams
8 of crack cause greater harm than the five grams of
9 methamphetamine, which is to say, even if the
10 collapsing were in the direction of leniency, it
11 would remain the case that the methamphetamine would
12 be punished harder than crack and hence also much
13 harder than powder cocaine.

14 So in summary, although there's nothing
15 intrinsic about methamphetamine that means it would
16 never make sense to have different schedules for
17 different forms, the market conditions today no
18 longer justify it and create the opportunity for
19 sort of arbitrary differences in sentencing.

20 And if they are going to be collapsed, and
21 if you think that the sentencing for cocaine is
22 ballpark correct, it probably makes more sense to

1 collapse in the sense that the ice and actual get
2 sentenced the way that mixture has been rather than
3 the other way around. Thank you.

4 CHAIR REEVES: Thank you, Dr. Caulkins.

5 I turn to my colleagues. Any questions
6 for this panel?

7 VICE CHAIR RESTREPO: Dr. Wagner, thanks
8 for being here today and for your written
9 submissions. So aside from publishing these
10 guidelines, the Sentencing Commission also does a
11 lot of teaching or education.

12 We work with judges, probation officers,
13 prosecutors, defense attorneys, and anybody that'll
14 listen. And we also do a lot of research. So how
15 can we best marshal those tools to address the
16 problems you've identified?

17 DR. WAGNER: Wow. I think maybe the one
18 most important thing I would say is that we all have
19 an image in our head that comes up when we talk about
20 a person who uses methamphetamine. And that image
21 like looks a certain way, right?

22 You're seeing a particular kind of person

1 in your head right now who is potentially unhoused,
2 maybe has a little bit of a wild look in their eye,
3 probably has some oral hygiene problems.

4 And I think one of the best ways that we
5 can actually address this problem is to think very
6 hard about those images and those stereotypes and
7 how that contributes to stigma around substance use
8 and how that creates conditions where it's very
9 challenging for people to address their substance
10 use issues, right?

11 Stigma and shame and discrimination in the
12 medical system and interactions with the criminal
13 legal system challenge people who already are having
14 a hard time getting their basic needs met.

15 So to the extent that we can use our powers
16 to educate people about the everyday realities of
17 people who are using drugs, about the millions of
18 Americans who are using methamphetamine and don't
19 look like that, and then marshal our research
20 enterprise to really identify more effective
21 treatments.

22 Right now, we only have a couple of

1 treatments that are effective in addressing
2 methamphetamine use disorder you'll hear about it
3 later from people who work in that field. One of
4 them is contingency management, which is very
5 expensive, very resource intensive, and we can't
6 always get it paid for using Medicaid.

7 We have no FDA approved medications for
8 the treatment of methamphetamine use disorder right
9 now. We have several promising candidates and you
10 have some of the country's experts in the room today
11 that you'll hear about this from.

12 But investing our resources educationally
13 in addressing stigma and stereotypes and
14 resource-wise in identifying more effective
15 treatments and addressing root causes, I think is
16 really where I would marshal our resources.

17 CHAIR REEVES: Next question. VC Murray.

18 VICE CHAIR MURRAY: Thanks so much to both
19 of you for being here, to both of you, but especially
20 to Dr. Caulkins who has become a frequent flyer.

21 Thank you for your third time here, I think,
22 recently.

1 I think one question that I'm interested
2 in, I think probably many of us and members of
3 Congress, et cetera, is what are the levels of
4 associated violence with meth use as opposed as
5 compared to other drugs just to get a purchase on
6 it.

7 Dr. Caulkins gave us sort of one way into
8 that question, which is looking at price relative
9 to other drugs and certainly price makes sense that
10 it would be an incentive to violence.

11 I'm wondering if either of you has experiential
12 studies that Dr. Wagner, based on the people you've
13 talked to, not anecdotal exactly, but on the ground
14 experience of whether what you would expect to see
15 based on the incentives is in fact what you see on
16 the ground or whether there are other confounding
17 factors. Thanks.

18 DR. WAGNER: I guess what I would say is
19 I've been doing this work for 25 years. I am trained
20 as an anthropologist and so we do our work in the
21 field with people. We spend a lot of time with
22 people.

1 So I have spent a lot of time with people
2 who use methamphetamine. I put my students in rooms
3 with people every day. We run a field site where
4 we're following a cohort of 300 people who use drugs
5 right now. I have never had a violent incident in
6 my office.

7 I have never been threatened. I have
8 never felt threatened. And so this goes back to
9 this other conversation about, I understand that
10 there is violence associated with trafficking
11 markets and I believe that to be true.

12 But on the day-to-day level of working with
13 people who use methamphetamine, that is not our
14 experience. And so there's a distinction to be made
15 there between the higher sort of trafficking
16 organizations and what goes on there and what's
17 happening every day in people's lives on the street.

18 DR. CAULKINS: I'm going to begin by
19 making reference to the genius paper by Paul
20 Goldstein all the way back to 1985. You guys might
21 have already heard this and I apologize if it's
22 redundant in that sense.

1 But when thinking about violence in the
2 crack era, Paul made this really careful and
3 thoughtful distinction between
4 psychopharmacological violence, which is the
5 violence committed by the person who's using the
6 substance, where alcohol, for instance, is very
7 problematic.

8 Economic compulsive violence, which is I
9 need money to buy the drugs so I will commit a
10 burglary or a mugging. And systemic, which is at
11 the time was sort of characterized as dealers
12 fighting dealers over turf. But a lot of it, but
13 it means violence by dealers.

14 It's often fights over deals gone bad or
15 discipline within trafficking organizations. And
16 at the time, Paul's main point was that systemic
17 violence is actually probably at least half. Now
18 that's a different drug in a different era.

19 But overall, there is an amount of violence
20 that comes from the use, but a lot of it really comes
21 from the trafficking. And that's why I was focusing
22 on the money to be made as an incentive.

1 But I will also say, and this is not a suck
2 up, I already wrote down here in response to your
3 earlier asking you that question that my colleagues,
4 Craig, Peter and I, if you should add one more column
5 to that analysis, which is guns seized for kilogram.

6 And we haven't done it, but we sure can. My best
7 guess is --

8 VICE CHAIR MURRAY: Can you get it done
9 by April. Just kidding.

10 MR. CAULKINS: Yes, absolutely. For sure
11 we can and will. My best guess is that in ballpark
12 terms, methamphetamine traffickers and cocaine
13 traffickers are sort of equally noxious to society
14 in this regard. But I am really curious to see on
15 that particular measure whether when we look more
16 carefully, there's any detectable difference.

17 CHAIR REEVES: Commissioner Meisler.

18 COMMISSIONER MEISLER: Thanks for being
19 here. I think I have one question for each of you.
20 Happy to hear experiences.

21 So I was struck, Dr. Wagner, by the
22 observation in your written testimony that what

1 appears to be pure crystal meth from a trusted source
2 is one of the primary ways that people attempt to
3 reduce their risk of exposure to contaminants,
4 including fentanyl.

5 And I guess I'm just wondering from your
6 experience whether users can tell the quality of
7 the meth that they're ingesting and whether they
8 seek out meth at a certain level of purity for
9 whatever reason.

10 DR. WAGNER: Thank you for the question.

11 I think the answer is it depends. I think it
12 depends on who you are and where you are and what
13 is available.

14 People have kind of an embodied sense of
15 how the drug feels and people have an understanding
16 based on their own experience of what it should look
17 like or what it should smell like or what it should
18 taste like.

19 The reality is that we don't actually know
20 because until very recently, we haven't had the
21 ability to validate those impressions against
22 what's actually there, which is another source of

1 investment that we could make if I can extend my
2 wish list to be a stronger surveillance network for
3 street drugs. People think they know and in many
4 times they're right.

5 We actually did another analysis that I
6 may have written about where we asked people what
7 drugs they had used and then we asked them to provide
8 a urine sample and we tested the drugs and the idea
9 was we were looking for unexpected drugs, right?

10 Our hypothesis was given this narrative
11 about fentanyl is in everything and all of the
12 contaminants in the market, that if we tested
13 people's urine, we would be seeing fentanyl more
14 often than they expected it to be there and what
15 we found was that they were pretty right on.

16 They knew what they had taken and if they
17 expected fentanyl to be in there, even if they were
18 methamphetamine, mostly using meth, if they
19 expected fentanyl to be in their urine, it would
20 be there and if it was there, they were not surprised
21 by it. So people are pretty good, but we could do
22 better if we had stronger surveillance.

1 COMMISSIONER MEISLER: Thanks.

2 And Dr. Caulkins, this is kind of on the
3 same theme of, at least as of interest to me, about
4 the relationship between market demand and what
5 users are demanding of controlled substances.

6 So you had noted in your written testimony
7 that given the guidelines, the distinction in the
8 guidelines and the penalty structure between ice
9 and meth actual on the one hand and mixture on the
10 other hand, that should have created incentives to
11 push the market towards selling less pure forms of
12 meth.

13 That hasn't happened. It's all pure,
14 we're hearing now.

15 I'm just wondering whether you think that
16 there could be countervailing market forces that
17 explain the absence of potentially a deterrent
18 effect, the idea being that if users are demanding
19 actual meth or ice because that's what's going to
20 deliver them the high they want, that overcomes the
21 potential incentives toward the less potent, less
22 pure drug that would actually achieve -- trigger

1 a lower sentence if that makes sense as a question.

2 DR. CAULKINS: Yes. So I love the way
3 you're thinking. You're saying, what the heck?
4 Why aren't these business people responding to
5 incentives more rationally? What are the
6 countervailing arguments? And I can think of
7 three.

8 One is the customers want the high quality
9 stuff. And if you're selling lower quality stuff
10 and they're able to detect it, then you might get
11 a bad reputation and reputation matters in these
12 markets.

13 Another argument is when it is more pure,
14 it's more compact, it's easier to hide. So you
15 reduce your risk of getting arrested.

16 And the third is the people who choose this
17 as a profession worry about law enforcement, but
18 they also worry about their business associates.

19 They are violent towards each other.

20 And when you are cutting material, you are
21 creating opportunities for disputes. And those
22 disputes cannot be taken to the Better Business

1 Bureau. So they're sometimes resolved in violent
2 ways. So when the drug is not adulterated or diluted
3 within the domestic distribution chain, it makes
4 things simpler in a way that reduces disputes.

5 So there are some arguments on both sides
6 and I'll act like an economist here. I'll say the
7 revealed preference of the market is that the
8 incentives for selling highly pure apparently have
9 trumped the incentive that comes from the sentence
10 differential.

11 COMMISSIONER MEISLER: Thanks, I'm going
12 to not cast on Dr. Wagner the desire for a Better
13 Business Bureau that resolves disputes among drug
14 dealers, but I like that thinking as well.

15 CHAIR REEVES: VC Mate.

16 VICE CHAIR MATE: Thank you, thank you
17 both for being here today. I really appreciate your
18 time and attention to this important issue. I
19 actually had a related question to sort of the
20 penalty structure and incentives, but a question
21 for both of you, maybe first for Dr. Wagner and then
22 for Dr. Caulkins.

1 Dr. Wagner, you kind of mentioned this,
2 that five grams might be something that an
3 individual using methamphetamine would possess.
4 I was wondering whether in your research, have you
5 seen people seek less pure forms because of the
6 penalty structure that we have?

7 Or that there might be this tripwire where
8 someone who's using methamphetamine would be, if
9 I have this more pure form, I'd be exposed to a higher
10 potential penalty. Have you seen that affecting
11 choices?

12 Is it a deterrent or, I guess not really
13 deterrent at that point, but just is it affecting
14 what people are seeking our penalty structure?

15 DR. WAGNER: Thank you for that question.
16 In my experience, no. And in the weeks before I
17 came here, I was talking to people and told them
18 what I was coming to do and I was asking them this
19 very question and they said, absolutely not.

20 Like, what is available to me is what's
21 available. And the threat of penalty and higher
22 versus lower sentencing does not seem to factor into

1 people's decisions as far as I can tell.

2 VICE CHAIR MURRAY: Did they know -- sorry
3 to cut in on Laura's question. Did they know about
4 the distinction or no?

5 DR. WAGNER: No, not until I told them.
6 And I live in Nevada, right? And so people are,
7 I think, more subjected to state laws and so it's
8 different, but no, they did not. I didn't talk to
9 everybody, but of the people that I talked to.

10 VICE CHAIR MATE: Thank you, that's
11 helpful.

12 And then Dr. Caulkins, I was thinking
13 about, you had talked about how the current
14 structure, we've actually seen an increase in
15 purity, which Commissioner Meisler was mentioning.

16
17 I'm wondering if we were to change that
18 penalty structure and not distinguish based on
19 purity, would you expect that to have any effect
20 on what's happening with the markets and the
21 structure of drug trafficking organizations?

22 And if so would like -- you know, where

1 that is, would that matter and the effect it might
2 have?

3 DR. CAULKINS: Sure answer is no. I would
4 guess that the most likely situation would continue
5 to be what's going on at present, which is production
6 of huge quantities in Mexico that enable it to be
7 distributed with very little dilution and at very
8 low prices.

9 CHAIR REEVES: Yes.

10 VICE CHAIR RESTREPO: Dr. Caulkins, if not
11 purity and weight, what markers do you suggest we
12 take a look at to determine relative culpability
13 in the drug markets?

14 DR. CAULKINS: I think what I'll say is,
15 I think what I heard in the first panel too, which
16 is the same things that one uses for any of the other
17 substances, which is us ducking your very good and
18 very difficult question.

19 It's hard to know how to assess
20 culpability. You know better than anyone else the
21 kinds of things that are built into the guidelines
22 already, they do have to do with role and whether

1 there are weapons present and so on. And in my view,
2 those additional factors, we should be looking to
3 find even more of them and to give them greater
4 salience. Purity is essentially useless for
5 methamphetamine. Quantity is itself only
6 imperfect because you can have a very minor role
7 person associated with a large quantity. So these
8 other indicators, which are less quantitative, less
9 objective, harder to establish, those are their
10 downsides.

11 I personally think we should be trying to
12 do more with them. But look, it's a very good
13 question. It's a very hard question. The point
14 though is meth is not different than cocaine or
15 opioids in this regard.

16 CHAIR REEVES: And may I follow up on that
17 question, Dr. Caulkins? I think you indicated that
18 you've been around for a long time. And I'm just
19 thinking back about the crack cocaine disparity and
20 how the commission and others viewed the distinction
21 between crack and cocaine.

22 And now, 25 years later, we say, ooh, we

1 were going down the wrong path. I'm not suggesting
2 that we've done the same thing with respect to meth,
3 but what are your thoughts on how we've approached
4 or how society has approached the issue with respect
5 to meth and purity versus mixture of whatever, ice?

6 DR. CAULKINS: Oh boy. Well, with all due
7 respect, and I do think you guys are great, I think
8 the commission is now on a wrong path with respect
9 to meth. It's debatable to me whether or not the
10 conditions 15 and 20 years ago justified the three
11 different schedules. I think genuinely you can
12 make arguments on either side.

13 But those reasons have disappeared. So
14 at present, it does strike me as a wrong path and
15 I'm delighted that this hearing is happening and
16 the wisdom of continuing the distinction in this
17 era of a changed market, I'm glad that it's being
18 discussed.

19 CHAIR REEVES: And Ms. Wagner, I do have
20 one follow up with respect to you mentioned the seven
21 grams, somebody being able to buy that and sort of
22 at a reduced cost to sort of feed their addiction,

1 if you will, over longer days or time. I'm just
2 thinking about the people who you service.

3 Those are typically users, I presume. And
4 if they are indicted for five grams of meth, that
5 might, in our system, trigger a mandatory minimum
6 of so many years. I'm just, you know, I'm trying
7 to think about if any of those persons you've
8 serviced have spent time in prison based on the
9 minimal amount of drugs that they were actually
10 caught possessing and or using.

11 DR. WAGNER: So are you asking of the
12 people that I work with, who are mostly end users,
13 have any of them been charged with these mandatory
14 minimum sentences?

15 CHAIR REEVES: Mandatory minimum or serve
16 mandatory periods of time in prison.

17 DR. WAGNER: I do not know the answer to
18 that. But I want to add one more thing. I live
19 in Nevada. Nevada is a very big state, the seventh
20 largest state in the country. We have two major
21 population centers, one in Reno, one in Las Vegas.
22 It takes eight hours to drive between them.

1 So if you drive from here eight hours
2 north, you're going to go through like seven states
3 and into Canada, right? That's how long it takes
4 to get from Reno to Nevada or from Reno to Las Vegas.

5 So, and methamphetamine is more prevalent, at least
6 now, and historically in the Western U.S.

7 So people travel a really long way. And
8 so not only might somebody have five grams because
9 it's really not that much, but also if they're
10 driving long distances in a very, very rural state,
11 people can't afford to travel that far. They can't
12 afford to make those trips daily.

13 So people can pool money, people will pool
14 their resources to make one purchase. That could
15 look like a lot of methamphetamine for somebody who
16 can just walk down the block. But in places like
17 Nevada and the rural West, the travel distances are
18 just so far and things are so sparsely populated
19 that people deal with different conditions.

20 CHAIR REEVES: Commissioner Wong, go
21 ahead.

22 COMMISSIONER WONG: Dr. Caulkins, you

1 made the case for how market conditions make kind
2 of the stratification between mixture and actual
3 no longer rational. And then your testimony kind
4 of closed with, so in which direction should we go?

5 And I'm wondering -- should the gap be closed?

6 And I wonder if there's an argument for
7 not going with the binary of one or the other, but
8 if so, what kind of considerations would you use
9 to determine where within the middle I should go?

10 DR. CAULKINS: The overall question of how
11 harshly we should punish drug traffickers is an
12 intrinsically difficult question in part because
13 it's a values judgment. It's not something that
14 science per se can just answer.

15 So the perspective I was taking was to say,
16 overall, there's not a lot of dissatisfaction being
17 voiced right now with the cocaine sentencing. So
18 let's think about methamphetamine and its harms
19 relative to cocaine. So I was sort of accepting
20 cocaine as those are okay. And if you buy that,
21 then the closing would be in this direction.

22 But absolutely, somebody else could say,

1 no, I think the crime of drug trafficking is just
2 worse. I believe that as a moral matter. And so
3 I think that the cocaine powder sentences, for
4 instance, are too low.

5 And I'd like to take the meth sentences
6 and do this and then bring the cocaine sentences
7 up to match. And I don't think as a scientist, I
8 could say that's wrong. That is ultimately sort
9 of a values judgment.

10 But if you think that the cocaine is about
11 right, then that's why I was suggesting that the
12 collapsing be done in the direction that I was
13 suggesting. Maybe I didn't --

14 COMMISSIONER WONG: No, no, I think I
15 thought it was -- I wonder if there are other
16 comparisons that would be helpful though, because
17 you use the baseline really of the 28 grams of crack.
18

19 And that's an area where I think there's
20 been a lot of flux in terms of, you know, even recent
21 charging policies and whether or not that would
22 correlate with those. You know, I think there is

1 a lot of debate over sort of where penalties go
2 there. And I'm just wondering if there are other
3 comparisons.

4 DR. CAULKINS: Right. So the idea is,
5 where's my chalkboard? I can't talk without a
6 chalkboard. So here are the two meth and crack and
7 powder. If we do this, then we're still treating
8 meth tougher than crack, which is also tougher than
9 powder.

10 COMMISSIONER WONG: You're assuming that
11 28 grams of crack is charged with the mandatory
12 minimum of five years. And that's where I'm saying,
13 I think, practically in the real world, there's --

14 DR. CAULKINS: Yeah, I was just looking
15 at the schedule weight ratios.

16 I don't know if I may. Chair Reeves, can
17 I offer a perspective on the question you just asked
18 Dr. Wagner about how changing conditions could lead
19 five grams to possibly not merit the sentence that
20 it did in the past?

21 CHAIR REEVES: Yes.

22 DR. CAULKINS: So one of the big

1 differences in methamphetamine now versus 20 years
2 ago is the price collapsed. Let's just use for
3 round terms a 90% decline to make the math simple.

4
5 To a first-order approximation, a lot of
6 the people who have their lives dominated by
7 methamphetamine are essentially spending a large
8 share of their disposable income on the drug. When
9 the price collapses, the biggest effect is they
10 might just be using a lot more pure milligrams per
11 day or per week or per month.

12 Price goes down 90% and they're consuming
13 10 times as many pure milligrams. And purity only
14 doubled. Purity went from 50% to 100%. That means
15 they're consuming five times as many grams of
16 mixture, which means their supplier is moving five
17 times as much. Their supplier's supplier is moving
18 five times as much.

19 Everybody up and down the chain, even when
20 they're only supporting the same number of chronic
21 users whose lives are affected in this awful way,
22 are all involved with five times as much weight as

1 before.

2 So the collapse in price and the response
3 of everybody just using more grams per day, in
4 effect, means everybody up and down that supply
5 chain is being caught with five times as many grams
6 as they were before the price collapse.

7 So the deflation in prices sort of kicks
8 in an automatic inflation in the length of the
9 sentence for people who are making the same money,
10 working the same number of hours, supplying the same
11 number of users.

12 CHAIR REEVES: Yes, Dr. Wagner. Yes.

13 DR. WAGNER: May I add a yes and? Because
14 from my understanding of people's use patterns, it's
15 not a linear relationship between a decline in price
16 and an increase in use, right?

17 If the price falls by half, I am not
18 automatically going to increase my use by half
19 because as a person who uses methamphetamine, I am
20 functioning in my daily life and I'm using it for
21 particular purposes and just more money in my pocket
22 does not mean that I'm going to automatically spend

1 all of that money on methamphetamine, right?

2 So there's some sort of curvilinear
3 relationship there where people might increase the
4 quantity that they use a little bit based on decrease
5 in prices, but people are also going to use that
6 money to buy food and to pay for an apartment.
7 They're going to use that money in other ways. So
8 yeah, yes, and.

9 CHAIR REEVES: Yes, VC Murray.

10 VICE CHAIR MURRAY: I had a question for
11 Dr. Wagner. So, until I read these materials in
12 preparation for this hearing, I had not realized
13 that pills were often different in terms of purity
14 level, like I thought we had totally moved away from
15 cocaine in Denmark, but actually we're in like a
16 little bit of a cocaine in Denmark situation where
17 obviously pills are the tail and not the dog. But
18 it seems like they are different in terms of purity.
19 I wonder if you see any pills, I don't know if it's
20 regional or whatever, and do you see any differences
21 in terms of users, or anything you've noticed about
22 pills?

1 DR. WAGNER: Thank you for that. I don't
2 really know. I don't know that we're seeing a lot
3 of pills where I am, but I don't have a good answer.

4 VICE CHAIR MURRAY: I have one more --

5 CHAIR REEVES: Yes.

6 VICE CHAIR MURRAY: So I was so interested
7 in your harms per unit weight charts. I know that
8 it has -- that you've carefully caveated that it's
9 based on 2016 data. Obviously, there have been some
10 changes in the market since 2016.

11 Do you -- can you extrapolate a little bit
12 back in the napkin? Do you expect to see changes
13 if we had 2024 data in these charts?

14 DR. CAULKINS: Yes. So you're absolutely
15 right. It's not a proportionality.

16 I was using that to make the point, simply
17 the economic term would be an elasticity of demand.

18 It's not literally minus one, but when prices are
19 going down, people tend to use more.

20 So the consumption per person year is
21 probably higher now than it was in the past, which
22 means that a given weight of methamphetamine will

1 support fewer person years in 2024 than in 2016.

2
3 So because meth prices dropped more than
4 cocaine prices over that period, it makes the
5 calculation conservative. So whereas in 2016, it
6 was ballpark parity, probably now I would guess that
7 a kilogram of methamphetamine supports fewer person
8 years than a kilogram of cocaine does.

9 VICE CHAIR MURRAY: Would you expect more
10 health harms? Because the assumption there is that
11 each person is consuming more.

12 DR. CAULKINS: So yes, the dose can make
13 the poison, but there is also tolerance, both
14 physiologically and behavioral adaptation. For
15 instance, choosing to smoke instead of inject.

16 So the harm is not linear in pure
17 milligrams consumed, but it is entirely plausible
18 that people who are dependent users in a market where
19 prices are very low and they're able to consume more
20 pure milligrams per day find it more difficult to
21 escape from that and to go into recovery.

22 VICE CHAIR MURRAY: I'm wondering, too,

1 if there are lots of chronic harms in terms of
2 cardiovascular issues, in terms of mental health,
3 schizophrenia-type issues, if you're going to get
4 a rise in deaths, emergency room visits, et cetera,
5 as people are using more.

6 DR. CAULKINS: So that's our question more
7 for the medical doctors, and you've got some awesome
8 people coming later. My guess is your intuition
9 seems exactly right, but I'd encourage you to ask
10 it again in the afternoon to the medical doctors.

11 CHAIR REEVES: Thank you so much. I
12 welcome you to stay around because, like you said,
13 we're going to hear great testimony later in the
14 day, and I appreciate everything that you all have
15 done so far.

16 Ladies and gentlemen, it is time for us
17 to take a 15-minute break. We'll be back after
18 that. Thank you so much.

19 (Whereupon, the above-entitled matter
20 went off the record at 10:53 a.m. and resumed at
21 11:12 a.m.)

22 CHAIR REEVES: Our third group of

1 panelists will provide us with the perspectives from
2 state and law enforcement agencies. First, we have
3 Mark Delaney from the Tennessee Bureau of
4 Investigation, where he serves as Special Agent in
5 charge of the Tennessee Dangerous Drug Task Force.

6 Second, we have Sergeant Timothy
7 Williamson, who serves as an Assistant Commander
8 of the Columbus Criminal Patrol Team of the Ohio
9 State Patrol, and as a uniformed task officer for
10 the DEA. And third, we have Sergeant Kyle
11 Williamson, who serves in the San Antonio Police
12 Department and is currently assigned to the South
13 Texas high intensity drug trafficking areas.

14 Mr. Delaney, thank you for coming. We're
15 ready to hear from you, sir.

16 MR. DELANEY: Thank you, thank you
17 Commissioner Reeves and fellow Commissioners. Good
18 morning and thank you for this invitation to testify
19 before you here today. My name is Mark Delaney,
20 and I am the Special Agent in Charge for the
21 Tennessee Bureau of Investigations, Tennessee
22 Dangerous Drugs Task Force.

1 On behalf of the Tennessee Bureau of
2 Investigation, Director David Rausch, over 375 law
3 enforcement agencies, and over 7.2 million
4 residents of the Volunteer State, I wish to update
5 you on the status of methamphetamine distribution,
6 production, and purity levels in our state.

7 By way of introduction, I have been in law
8 enforcement profession now for a total of 26 years.

9 During this time, I've had the opportunity to be
10 directly and indirectly involved in the
11 investigation of clan lab drug laboratories, drug
12 trafficking organizations, and criminal
13 enterprises at the local, state, and federal levels.

14 I currently oversee the Tennessee
15 Dangerous Drugs Task Force, which started in 1999
16 to confront the methamphetamine epidemic plaguing
17 counties in East Tennessee. The Methamphetamine
18 Task Force, as known today, is known as the Tennessee
19 Dangerous Drugs Task Force, or the TDDTF. It has
20 grown to an organization that now encompasses all
21 95 counties in the State of Tennessee.

22 All local law enforcement agencies are

1 members of the task force, as well as the Tennessee
2 Bureau of Investigation, the Drug Enforcement
3 Administration, and all three of the state's United
4 States Attorney's Offices.

5 The mission of the Tennessee Dangerous
6 Drugs Task Force by way of the TBI, is to reduce
7 the availability and illegal use of harmful schedule
8 drugs, including methamphetamine, marijuana,
9 prescription drug diversion, heroin, cocaine,
10 fentanyl, and others.

11 By educating the public about the dangers
12 of all schedule drugs, by increasing public safety
13 through supplying equipment, training,
14 intelligence, and investigative tools to assist law
15 enforcement and prosecutorial authorities in
16 strategically identifying, targeting, and
17 prosecuting drug offenders.

18 By networking with law enforcement
19 agencies, regulatory agencies, health providers,
20 treatment providers, and local drug coalitions, and
21 by protecting the public and the drug endangered
22 children of Tennessee, from the harmful effects of

1 manufacturing, distribution, and illegal use of
2 schedule drugs.

3 The TBI, through the Tennessee Dangerous
4 Drugs Task Force, provides training, equipment,
5 hazardous material response vehicle,
6 pill-take-back collections, and adjudicated waste
7 incineration for law enforcement.

8 Our Task Force also employs the state's
9 Handle With Care coordinator and the Tennessee
10 Alliance for Drug Endangered Children coordinator,
11 who are both tasked to promote school-community
12 partnerships aimed at ensuring that children who
13 are exposed to trauma in their home, school or
14 community, receive appropriate intervention to help
15 them achieve academically at their highest levels,
16 despite whatever traumatic circumstances they may
17 have endured. The goal of the Handle With Care
18 program is to ensure that students succeed in
19 school.

20 The trends in Tennessee. Tennessee has
21 often been referred to as the Methamphetamine
22 Capital of Appalachia. This is obviously, not a

1 title that the law abiding citizens of Tennessee
2 are proud to claim. And numerous efforts,
3 including education, prevention, and enforcement
4 are ongoing to attempt to minimize the effects of
5 methamphetamine distribution in Tennessee.

6 Recent trends continue to demonstrate a
7 significant reduction in the detection of domestic
8 clan, clandestine methamphetamine laboratories in
9 Tennessee. This reduction is believed to be due
10 to state and federal laws that have limited the
11 availability of precursor ingredients needed to
12 produce methamphetamine.

13 Additionally, the readily available
14 supply of highly potent and pure methamphetamine
15 imported from source countries through our borders
16 and into the United States, has contributed to the
17 decrease of domestically produced methamphetamine.

18 Drug cartels continue to develop new
19 techniques and business models to ensure the
20 successful importation of methamphetamine into the
21 United States, and ultimately into the hands of the
22 methamphetamine consumers across the country,

1 including the State of Tennessee.

2 Purity levels. It is not uncommon for
3 Tennessee law enforcement to discover purity levels
4 of imported methamphetamine exceeding 90 plus
5 percent. It has been my historical experience,
6 that the purer the level of methamphetamine
7 discovered, directly correlates with the proximity
8 of the source of supply in the supply chain.

9 However, this trend continues to evolve
10 and is ever changing. It is now, not uncommon, to
11 discover a lower level of drug trafficker,
12 distributing methamphetamine that is very pure.
13 Plainly stated, source countries and drug cartels
14 have such large quantities of methamphetamine on
15 hand that there is no need to cut or add other types
16 of substances to the methamphetamine before it is
17 positioned into the distribution pipeline.

18 Unfortunately, the same is now true for
19 the purity methamphetamine distributed by
20 lower-level drug traffickers. Based on
21 conversations with prosecuting United States
22 Attorneys, Tennessee District Attorney General's

1 TBI Special Agents, DEA Special Agents and Task
2 Force Officers in Tennessee, they continue to seize
3 methamphetamine with alarming levels of purity, in
4 the 90 percent purity level.

5 It continues to be common practice and is
6 now expected for cases prosecuted in Tennessee
7 Federal Courts, to see an alarmingly level, high
8 level of purity of methamphetamine.

9 The community impact. The Tennessee
10 Bureau of Investigation's Drug Investigation
11 Division attempts to prioritize active drug
12 investigations, based off predicted impacts that
13 can identify and be minimized through the
14 utilization of traditional and non-traditional
15 investigative techniques.

16 Unlike fentanyl, which can cause sudden
17 death to the consumer, methamphetamine typically
18 continues for a longer duration, causing an extended
19 period of harm to communities. For example, an
20 extremely rural area of Tennessee can be saturated
21 with highly pure methamphetamine which will over
22 a period of time, devastate the community, the

1 consumer, their family, and the community either
2 directly or indirectly.

3 Our agency attempts to target the
4 distributors of methamphetamine into these smaller
5 communities as these are often the hardest hit areas
6 and require more resources to effectively dismantle
7 drug trafficking organizations.

8 In conclusion, and for some
9 considerations, drug trafficking organizations are
10 very savvy and understand their trade and potential
11 risk and penalties associated with their criminal
12 enterprise. I submit that based on the trends and
13 patterns referenced above, that law enforcement,
14 prosecutors, and judges at the state and federal
15 level need every available tool and resource
16 available to detect, prosecute, and sentence those
17 found to be distributing methamphetamine into our
18 communities.

19 While more individuals, not just those at
20 the top of the business enterprise, are arrested
21 and charged with a purer form of methamphetamine,
22 I would submit that should not equate to lesser

1 sentence because of the dangerousness and
2 prevalence of the methamphetamine in our
3 communities continues to increase.

4 If drug trafficking organizations detect
5 any level of leniency or potential lesser penalty,
6 it is my belief that drug trafficking organizations
7 will unequivocally change their distribution
8 strategies and business models to receive any
9 potential benefit of the adaptation of their
10 business models.

11 Thank you for the opportunity to relay this
12 information from Tennessee and we welcome any
13 questions.

14 CHAIR REEVES: Thank you, Mr. Delaney, for
15 these speculations.

16 MR. DELANEY: Thank you.

17 CHAIR REEVES: Sergeant Williamson.

18 MR. T. WILLIAMSON: Good morning, I'm
19 Sergeant Williamson with the Ohio State Highway
20 Patrol. I spent many years working in drug
21 interdiction and criminal investigations, not just
22 here in Ohio, but across the country.

1 CHAIR REEVES: Move your microphone just
2 a little bit closer to you, sir. Thank you.

3 MR. T. WILLIAMSON: Is that better?

4 CHAIR REEVES: Yes, a little bit better.

5 MR. T. WILLIAMSON: Okay. I don't know if
6 it's working.

7 CHAIR REEVES: Right.

8 MR. T. WILLIAMSON: All right. Today I
9 want to share what we're seeing on the ground when
10 it comes to methamphetamine trafficking. How it's
11 changed? Who's involved and why consistent smart
12 sentencing matters more than ever?

13 Meth trafficking in Ohio has exploded.
14 In 2024 alone, the Highway Patrol handled over 860
15 cases that dealt with methamphetamine. We seized
16 more than 500 pounds of the drug, and with the stats
17 on that, that's a 2,000 percent increase in cases.

18 And a 3,000 percent increase in volume, based on
19 the numbers from 2010.

20 Back in 2010, up until about 2016, meth
21 was produced locally in Ohio. Small batches, we
22 called them, one pot, or single pot labs. But since

1 2016, most of what we seize now, comes from the
2 Transnational Criminal Organizations, the cartels,
3 where it's produced in massive super labs run by
4 Transnational Organizations.

5 Essentially, what happened was similar to
6 the opioid crisis, that exploded in Ohio as well,
7 and in the mid-west when we cracked down on the
8 prescription drugs, the opioid painkillers. When
9 we made that much harder for people to get, then
10 that opened an enterprise for the cartels to exploit
11 that with heroin and fentanyl.

12 Same thing essentially, happened with
13 methamphetamine when we took Sudafed and placed it
14 behind the counter at your drugstores pharmacies,
15 things like that. That eliminated the ability for
16 the one pot, single pot labs to be produced locally.

17 Whether it be in a car, or in a house.

18 And with Sudafed not being readily
19 available, the cartels came in. They produced,
20 were able to supply massive amounts of meth at pure
21 levels very cheap. Most of the meth now that we
22 seize in crystal form, we commonly call that, ice.

1 We also see it smuggled in liquid. A big thing
2 now is pills, illicit pills.

3 It's often hidden in hidden compartments
4 in vehicle's fuel tanks. It's also being mailed
5 from source countries directly to people's front
6 doorsteps through consignment packages and the
7 mail. Whether it's ice, a mixture or a pill,
8 essentially, it's the same product. And for law
9 enforcement the distinction with that doesn't
10 change how we operate.

11 All the meth that we're seeing today is
12 over 90 percent pure, in Ohio. Meth trafficking
13 just isn't about drugs. It's about safety. In
14 2024 the Highway Patrol had 57 cases that involved
15 a firearm. That's a nearly 7 percent increase from
16 just the 2 percent that we saw with meth cases that
17 had firearms in 2010.

18 These encounters often are, for law
19 enforcement, are during traffic stops. And that
20 puts our officers in real dangers. And it's
21 happening more and more. Meth trafficking often,
22 meth traffickers often have long criminal

1 histories. We see both low-level couriers and
2 high-level distributors because meth is so cheap
3 and pure.

4 More people from more communities are
5 getting involved. Essentially, what we're seeing
6 is a meth addict can essentially be a meth trafficker
7 or distributor due to the high purity and the low
8 cost, and the massive amounts that our communities
9 are flooded with.

10 Federal data has shown that traffickers
11 are more likely to be white and female compared to
12 those involved with other drugs. And many of those
13 traffickers play very minor roles within these
14 organizations.

15 Here's a real issue. Ohio law focuses on
16 total weight, not purity. It's a containment
17 state. So, essentially when we submit our drugs
18 to our lab, we're merely testing for the presence.

19 And that's prosecutable in the State of Ohio, at
20 the state level.

21 Federal law focuses heavily on purity and
22 imposes mandatory minimums at much lower weights.

1 That means that essentially the same meth
2 trafficker could face very different sentences
3 depending on where they're prosecuted, even though
4 the meth is all the same with that 90 percent or
5 more purity. This is the kind of severity that
6 weakens public confidence in every part of our
7 system.

8 Meth isn't just a drug, it's a community
9 problem -- it's not just a drug problem, it's a
10 community problem. We see the effects everywhere,
11 mental illness, property crime, child neglect, and
12 poverty. Meth addiction is long lasting. It's
13 harder to treat and is devastating to families and
14 neighborhoods.

15 In 2024, we seized nearly 300 pounds of
16 meth on a single traffic stop in Ohio. This was
17 the second largest seizure in the state history.

18 The climate today, the most recent OSP lab report
19 data shows that the second quarter of '25, confirms
20 methamphetamine remains the most commonly seized
21 illicit drug in the State of Ohio.

22 Despite a 12 percent decrease from the

1 first quarter of '25, methamphetamine still led all
2 other drugs with 194 cases. That outpaced cocaine
3 at 20 percent, fentanyl at 11 percent, with all other
4 illicit substances being seized in the single
5 digits. Methamphetamine has not only sustained its
6 position as the most dominant drug in Ohio's illicit
7 market. But its widespread availability and high
8 purity continue to challenge law enforcement's
9 ability to keep pace.

10 The larger trend remains clear.
11 Methamphetamine is a primary threat to public safety
12 and community well-being in our state. These
13 findings reinforce the need for our continued
14 investment and interdiction operations, forensic
15 lab capacity, policy consistency, and addiction
16 resources that are available.

17 The meth problem is not going away. We
18 need strong interdiction tools, lab testing, and
19 sentencing that reflects what's actually happening
20 on the street. Law enforcement's goal is simple.

21 We protect communities, reduce harm and apply
22 justice fairly.

1 Thank you for your time this morning. I
2 look forward to any questions you may have.

3 CHAIR REEVES: Thank you, Sergeant
4 Williamson.

5 (Laughter.)

6 CHAIR REEVES: Sergeant Williamson.

7 (Laughter.)

8 MR. K. WILLIAMSON: Good morning,
9 Chairman Reeves and Members of the Committee.
10 Thank you for the opportunity to testify on the
11 subject of methamphetamine. I am a Sergeant with
12 the San Antonio Police Department and have been a
13 member of the law enforcement profession for the
14 past 26 years.

15 I currently serve as a Co-Commander of the
16 South Texas HIDTA Investigative Support Center in
17 San Antonio, Texas. The HIDTA Program is a program
18 funded through the Office of National Drug Control
19 Policy within the Executive Office of the President
20 which provides funding assistance to federal,
21 state, local and tribal law enforcement agencies
22 operating in areas determined to be critical

1 drug-trafficking regions of the United States.

2 The South Texas HIDTA is an alliance of
3 76 different law enforcement agencies working in
4 close partnerships to promote and facilitate
5 counter-drug investigations, information sharing,
6 operational coordination and officer safety. It
7 currently encompasses fifteen designated counties
8 along the US/Mexico border and includes the cities
9 of San Antonio in Bexar County and Austin in Travis
10 County.

11 The agencies involved recognize that our
12 goal of disrupting the market for illegal drugs by
13 dismantling or disrupting drug trafficking and/or
14 money laundering organizations, is the best
15 approach we can take to reduce the availability of
16 drugs to our communities.

17 Methamphetamine is a substantial threat
18 to the nation. The methamphetamine seized within
19 the South Texas HIDTA area of responsibility or AOR,
20 is pronounced -- or sorry, is produced in Mexico
21 where production amounts are rising as evidenced
22 by recent seizures of historically large amounts

1 of the drug.

2 Production of the drug does not rely on
3 climate or environment, making it a profitable
4 choice for Cartels, Transnational Criminal
5 Organizations and Drug Trafficking Organizations.
6 Mexico remains as the top foreign supplier of
7 methamphetamine to the United States, where the
8 South Texas HIDTA AOR is an integral entry point
9 of the drug.

10 Mexican cartels and their proxies continue
11 to market their methamphetamine supplies to
12 consumers in the U.S. The battles among the cartels
13 for control of various border plazas remain violent,
14 placing citizens on both sides of the border in
15 harm's way. Drug traffickers prey on young adults
16 on the border to transport their illicit drugs to
17 areas in the interior of the country.

18 Methamphetamine is imported into the
19 United States in several forms, powder, crystal or
20 ice form, dissolved in solution, and tablets or
21 pills. Methamphetamine is smuggled into and
22 throughout the United States via the use of

1 commercial and private vehicles, passenger buses,
2 river crossings, pedestrians and parcel delivery
3 systems.

4 In 2004, law enforcement agencies reported
5 seizing 23,703 methamphetamine production labs or
6 clan labs, in the U.S. The Combat Methamphetamine
7 Epidemic Act of 2005 significantly disrupted the
8 production of methamphetamine in the United States.

9 Today, methamphetamine production
10 laboratories are rarely encountered and have
11 shifted to the methamphetamine conversion labs
12 necessary to recrystallize the methamphetamine in
13 solution to crystal meth.

14 In 2024, South Texas HIDTA initiatives
15 seized 15,128 kilograms of ice methamphetamine, 168
16 kilograms of methamphetamine in solution, 2,761
17 kilograms of powder methamphetamine, 33,485 tablets
18 of methamphetamine, for a total of 18,057 kilograms
19 seized. These weights are an increase of 127
20 percent, over 127 percent from weights seized in
21 2023.

22 The drug price per kilogram is dictated

1 by the physical location of the drug, its distance
2 from the point of importation to distribution, and
3 its availability. 2024 per kilogram prices in the
4 South Texas HIDTA AOR are as low as \$2,000 compared
5 to \$15,000 per kilogram in 2021, which is an 87
6 percent decrease in cost.

7 This reduction in price has increased the
8 number of drug trafficking organizations that have
9 become involved in the importation and distribution
10 of methamphetamine across the United States.

11 Meth is a highly addictive drug with potent
12 central nervous system stimulant properties. In
13 2024, the South Texas HIDTA AOR experienced a slight
14 decrease of 1.69 percent in adults that were
15 admitted for the treatment of methamphetamine use
16 disorder from 2023 totals.

17 Children on the other hand, under 18 years
18 of age seeking treatment for methamphetamine use
19 disorder, increased over 66 percent in 2024.

20 Seizure amounts coupled with treatment statistics
21 demonstrates methamphetamine's availability and
22 affordability to users.

1 The DEA 2023 Office of Forensic Sciences'
2 Annual Methamphetamine Report states the average
3 purity of domestically seized samples was 94.9
4 percent nationwide, with seizures made in Texas
5 having maximum purity of 99 percent.

6 In years past, it was thought that
7 possession of high-purity methamphetamine product
8 indicated a prominent role in criminal enterprise.

9 Purity of a drug no longer defines the ranking
10 status of a distributor. Purity level is now driven
11 by customer demand.

12 The pervasive availability of
13 methamphetamine and its higher purity concentration
14 only exacerbates the addictive value of the drug.

15 Like PCP, methamphetamine use can cause aggressive
16 and hostile behavior and is associated with property
17 and violent crimes.

18 Aggression is often directed at family
19 members and those individuals in close contact with
20 methamphetamine addicts. The physical and mental
21 need to feed the addiction causes methamphetamine
22 users to commit burglaries, robberies, and thefts

1 to obtain anything of value to purchase more of the
2 drug.

3 Methamphetamine is classified as a
4 psychostimulant with abuse potential. This category
5 also includes a myriad of prescription medications
6 as well as MDMA, amphetamine, and cathinones.

7 Deaths from psychostimulants have been increasing
8 on a yearly basis since 2011 and sharply increasing
9 since 2019.

10 In 2023, the Centers for Disease Control
11 and Prevention reported 36,251 psychostimulant drug
12 overdose deaths in the United States, a six percent
13 increase from the previous year. Through October
14 2024, provisional CDC data recorded 30,023 overdose
15 deaths from psychostimulants.

16 Based on recent multi-hundred-kilogram
17 weight seizures, we believe methamphetamine
18 importation weights will increase and will maintain
19 a high purity rate. The abundant availability of
20 methamphetamine will also drive an increase in
21 violent criminal activity particularly in those
22 areas of the country that have a large user

1 population.

2 In an effort to stem the tide of addiction
3 and overdose of methamphetamine, our law
4 enforcement partners agree that actions must have
5 consequences. We applaud courts and prosecuting
6 attorneys that recommend and impose strict
7 sentences on drug trafficking violators to deter
8 their involvement in the distribution of drugs to
9 our citizens.

10 Violent actions coupled with addictive
11 levels of high-grade drugs should always be a
12 consideration for punishment rendering. Any
13 change in our laws that minimizes the consequences
14 of actions by these monsters gives the impression
15 that our society is willing to tolerate the abuse
16 of our public by individuals that care not about
17 who they hurt as long as there is a monetary gain
18 for them.

19 I thank you for the opportunity to testify
20 about the evils of methamphetamine and its
21 devastating effects on our community. I'm happy
22 to answer any further questions you may have.

1 CHAIR REEVES: Thank you so much,
2 gentlemen. Any questions from my colleagues?
3 Commissioner Wong.

4 COMMISSIONER WONG: Thank you so much for
5 all being here. I wanted to pick up on something
6 that Special Agent Delaney said, but I think open
7 to all of you all. Special Agent Delaney, you
8 mentioned how smaller communities are often the
9 hardest hit. And I wonder, sometime there's a
10 tendency to associate kind of the larger and more
11 sophisticated drug trafficking organizations with
12 the greatest harm.

13 And I'm wondering if what you see on the
14 ground is actually, sometimes outsized harms from
15 less sophisticated organizations in these small
16 communities? And just what kind of, what you're
17 seeing?

18 MR. DELANEY: Think about the supply chain
19 in terms of where's the ultimate source at? And
20 how many links are in that chain to reach the smaller
21 communities, right? So, what's a huge organization
22 inside of a small community, may in the whole term

1 or the whole scope of the supply chain, may be the
2 bottom of the supply chain. But it's still
3 significantly impacting that smaller community.

4 COMMISSIONER WONG: And just to follow up
5 on that. In terms of efforts to work your way up
6 the supply chain, how often are you seeing that
7 happening in investigations, maybe in partnership
8 with federal authorities? And what are some of the
9 challenges to tracing back supply?

10 MR. DELANEY: We have a great relationship
11 with our federal partners. We have Task Force
12 Offices assigned to virtually every federal agency
13 in the country. So, we routinely use our Task Force
14 Officers to take up some of those larger
15 investigations, if they haven't initiated it
16 themselves.

17 We do oftentimes rely on our federal
18 partners, whether that be our Task Force Officers
19 or our Special Agents that are assigned in those
20 areas. So, to answer your question directly, we
21 do rely upon federal law enforcement heavily.

22 CHAIR REEVES: VC Restrepo.

1 VICE CHAIR RESTREPO: Gentlemen, thanks
2 for being here. Sergeant Kyle Williamson, I
3 believe in your written submission, you wrote the,
4 "Purity of a drug no longer defines the ranking
5 status of a distributor." Given that we're moving
6 towards a lot more purity, so, what should we be
7 looking in terms of differentiating folks in this,
8 in the distribution chain, as to who is more or less
9 culpable, other than purity?

10 MR. K. WILLIAMSON: That's obviously a
11 difficult question, you've been trying to hit all
12 day, I think. But --

13 VICE CHAIR RESTREPO: Yes, yes, it's my
14 thing, the same question.

15 MR. K. WILLIAMSON: You have to look at
16 the amount. I mean, in my experience, you know,
17 just because somebody may not look like the, you
18 know, cartel type or something. Doesn't mean
19 they're not moving that weight for the cartel, you
20 know, and I believe you understand what I'm saying.

21 So, very rarely you're going to see some
22 street-level user with 10 pounds of ice on him.

1 You know, what I mean. So, at a certain point,
2 weight has to come into play. I think that's a big
3 thing. To -- I'll just leave it at that.

4 I mean it's a difficult question, but the
5 totality of the circumstances when you have the
6 information that this guy's dealing with 10 guys
7 and they got 10 guys under them, and that kind of
8 thing. And we have that kind of intelligence, that
9 obviously has to play a part.

10 VICE CHAIR RESTREPO: Sure.

11 MR. K. WILLIAMSON: You know, minus all
12 that, if you take all that away, you don't have that.

13 At a certain weight you have to take that, weigh
14 that more heavily, I think. That's my opinion.

15 VICE CHAIR RESTREPO: Thanks. Same
16 questions for Sergeant Timothy Williamson and
17 Special Agent Delaney. If you have any insights
18 for us.

19 MR. T. WILLIAMSON: Yes, I'd piggyback off
20 of what Sergeant said here. I mean it's tough
21 because now a days with meth, kind of what we're
22 seeing in Ohio is, you know, you can get a package

1 in the mail to somebody that's merely an end-user,
2 and that supply could be a couple pounds. Whether
3 it be, illicit pill form or in crystal ice form.

4 And that can, you know, sustain their
5 addiction as well as it allows them the opportunity
6 to benefit from that. And continue that addiction
7 by, you know, trafficking the rest of what they have
8 from that supply to somebody else.

9 MR. DELANEY: I would say almost
10 identically the same thing. You've got to look at
11 the totality of the circumstances to determine each
12 member of the conspiracy, or each member of the
13 organization's role. Whether that be like
14 previously mentioned, the enforcer, the
15 distributor, the courier, the manufacturer, all of
16 those are certainly significant roles inside of the
17 organizations that have to be considered.

18 How you develop that matrix, that
19 quantifies that, that describes that is the elephant
20 in the room, right? That three panels have sat
21 through and tried to give you a definitive answer
22 about. And it's just not there, yet, though I

1 certainly welcome more conversations and input.
2 There's a lot of smart people that need to get
3 together to determine that.

4 VICE CHAIR RESTREPO: Thank you. Thanks
5 to all three of you.

6 CHAIR REEVES: VC Murray.

7 VICE CHAIR MURRAY: Thanks to all three
8 of you for your testimony. I have a question about
9 overdoses. The numbers on overdoses are obviously,
10 very alarming. The increases, the total numbers.

11 I wondered if you could put a little flesh on those
12 bones, especially in light of the testimony we heard
13 previously, about Nevada users who were sort of
14 reporting that there weren't kind of sudden meth
15 deaths.

16 What kind of overdoses are you seeing in
17 person? Are you seeing, are these chronic
18 illnesses, are they, is it that there's a
19 combination of meth and other drugs? Are you seeing
20 something different than what those folks are seeing
21 in Nevada? Thanks.

22 MR. K. WILLIAMSON: I'll start by saying,

1 are we seeing meth overdose deaths? Yes. It's
2 hard to put a number on that because, one, what we're
3 seeing a lot lately is overdose deaths with multiple
4 drugs in their system. So, which one killed them?

5 And to say, and again, you have to know
6 this person died by an overdose, and they're testing
7 for that. There's a lot of missed statistics there,
8 so it's hard to put a number on that but if somebody
9 dies of a heart attack because they used too much
10 meth. To me, they didn't die of a heart attack,
11 they died of meth.

12 I mean that's like me saying, if I stab
13 you in a femoral artery, you died of bleeding out.

14 Not, you know, that of being stabbed. So, one is
15 causing the other and, yes, we're seeing it. It's
16 just hard to put a number on that just for various
17 reasons.

18 MR. T. WILLIAMSON: It's the same in Ohio.

19 We are seeing overdoses from it. Again, we can't
20 say exactly it's meth that's causing the overdose.

21 There's so many polydrugs out there, or CUDS, you
22 know, illicit pills that come in.

1 It can be 90 percent pure meth but also
2 have fentanyl or carfentanil or something else
3 that's cut in with it as well. So, as far as the
4 actual numbers on the meth only overdoses, I don't
5 know as that you would have an accurate depiction
6 of that.

7 MR. DELANEY: Hate to use the simplistic
8 analogy of an athletic event, but in the terms of
9 meth versus fentanyl, you know, you're essentially,
10 if you're looking at consuming fentanyl, it would
11 be a sprint to death. If you're looking at
12 consuming methamphetamine, it would be a marathon
13 to death, right? The ultimate, the end game if you
14 will, without intervention, without treatment,
15 without someone getting off of the illicit
16 substance, is death, right? So, you're looking at,
17 do you want it to be a sprint or a marathon?

18 Now, in terms of simplicity, that's kind
19 of the way we break it down. And I will add, in
20 Tennessee, we are a by-weight state, we run the gamut
21 from a half a gram to 300 grams. So, that's your
22 lowest level to your highest level felony, is a half

1 a gram to 300 grams of methamphetamine. Thank you.

2 CHAIR REEVES: VC Mate.

3 VICE CHAIR MATE: Thank you. I want to
4 echo everyone's thanks to you all for being here
5 and for sharing your thoughts with us. I appreciate
6 it. I had a question for Sergeant Timothy
7 Williamson, Mr. Delaney -- Special Agent Delaney
8 didn't get that memo on the required name, last name
9 for this panel.

10 (Laughter.)

11 VICE CHAIR MATE: But you mentioned Ohio
12 sentencing and how different it is from what's going
13 on federally. And I'm just, I was curious. If you
14 have an individual with five grams of meth, and
15 they're convicted in Ohio. What happens to them
16 at this sentencing stage?

17 MR. T. WILLIAMSON: It would trigger a
18 mandatory. It's a, we call it an MDO. It's a
19 mandatory offense that there's mandatory prison
20 time associated with that. It's essentially the
21 same as what the federal system can trigger as well.

22 But we're not doing that based on purity.

1 We're a containment state only. So, whatever
2 substance you may have, if the lab result comes back
3 as methamphetamine, at any, in any form or purity,
4 it's -- five grams is all five grams of containment.

5 VICE CHAIR MATE: And -- that's helpful,
6 thank you. And then but just to and to follow up
7 on that a little bit. Does the weight matter? And
8 are there other factors that would be considered
9 at sentencing, other than it is methamphetamine?
10 Are there other factors?

11 MR. T. WILLIAMSON: It would be weight,
12 yes. So, it starts with any possession of meth in
13 Ohio, at any amount is a felony. It triggers the
14 lowest level felony. And then there are standards
15 up to grams of what would be FF1, a first-degree
16 felony or second-degree, which would be our highest
17 that then trigger that mandatory sentencing.

18 VICE CHAIR MATE: Okay. Thank you,
19 that's helpful. And are there other sort of maybe
20 enhancements that go with anything, like gun
21 possession. Would that affect sentencing or other
22 kind of, maybe other factors that identify a higher

1 levels also --

2 (Simultaneous speaking.)

3 MR. T. WILLIAMSON: It would be up to the
4 prosecutor on that, at the state level for the
5 trafficking enhancement. And if there is the
6 trafficking enhancement or spec on that charge,
7 then, yes. That would possibly be a separate charge
8 that would allow more time.

9 VICE CHAIR MATE: Thank you. That's
10 helpful.

11 CHAIR REEVES: I have a -- oh, I'm sorry.
12 Go, go, no, no. Go ahead, Commissioner.

13 COMMISSIONER WONG: I think we can move
14 on, but you --

15 CHAIR REEVES: No, no. Go ahead
16 Commissioner Wong.

17 COMMISSIONER WONG: I just lost my
18 thought.

19 CHAIR REEVES: All right, apologize.
20 Sergeant Williamson, and then I have a question for,
21 I think Agent Delaney.

22 With respect to Ohio's testing of drugs,

1 I think you mentioned that they do a lot of testing,
2 or you have different lab tests that you do. How
3 long is it taking the State of Ohio to do the drug
4 testing for any particular drug. I mean what's the,
5 is there a delay?

6 MR. T. WILLIAMSON: The climate today is
7 a lot better. You go back to a year ago or two years
8 ago, we had our limitations. There were times where
9 we would submit a case, and we may not get the lab
10 results, we may not receive those results for
11 anywhere from 3 to 6 months. And that's in the time
12 of where, those cases are being tried in court.
13 And you may not have those lab results.

14 Now, we do have the option to expedite
15 those in certain cases but there is a delay. It
16 is straining on our lab. And it's like anything
17 else, personnel, equipment, facilities. We
18 actually did, the Ohio Highway Patrol did just
19 renovate space for storage capacity and testing
20 capacity. But we are in the process of building
21 a new lab due to the demand of the amount of testing
22 that we require.

1 CHAIR REEVES: Do you know what it's
2 costing the State of Ohio to --

3 MR. T. WILLIAMSON: I can get it.

4 CHAIR REEVES: All right. Okay, thank
5 you. And Special Agent Delaney you were talking
6 about the matrix, I think at one time. You know
7 how this might look with the end-user being a piece,
8 the mid-level person, the supplier and all these
9 others. Suppose this, you know, 300 grams of stuff
10 that's going through or to the particular community
11 that Commissioner Wong, referenced. And obviously
12 everybody plays a role in making it happen.

13 The end user who may get it, some amount
14 of drugs at his or her home, who uses just to sort
15 of feed the addiction that the person has, but also,
16 making money by selling it to others. And then,
17 you know, all those persons in between.

18 And then I'll ask, I guess I'll ask three
19 of this. Do you think each individual, they do play
20 a role in it? Should each individual be treated
21 the same, as far as penalties go?

22 MR. DELANEY: So, in the state system in

1 Tennessee, if we charge a conspiracy to distribute
2 300 grams of methamphetamine, that actually,
3 possession of 300 grams is a Class A Felony. The
4 conspiracy side of it, as opposed to the way it is
5 in the federal system, is an upcharge. In the
6 state-side of Tennessee, it becomes a Class B
7 Felony.

8 So, the conspiracy to distribute 300 grams
9 becomes one charge less than the ultimate charge
10 of the Class A Felony, which is obviously the
11 opposite of the way it is in the federal system.

12 The federal system, the conspiracy is the trump
13 charge. That's where the time comes from. Did
14 that answer your question?

15 CHAIR REEVES: Well, I guess, I guess.
16 But in trying to fashion the penalty with, separate
17 and apart from the conspiracy. To sort of fashion
18 what sort of penalty individuals might face, should
19 they be treated the same?

20 MR. DELANEY: I think they have to.
21 Ultimately, they're all an integral part of that
22 chain or that source of supply down the chain. So,

1 I mean to say that somebody, you know, takes 200
2 of the 300 grams, are they less culpable than the
3 person that had 300 grams by weight? Yes,
4 obviously, by role, no. By role, they are the
5 ultimate, the link in that chain that continues that
6 supply.

7 If that person that took the 200 grams
8 didn't distribute that 200 grams of
9 methamphetamine, obviously that would be the end
10 game, right? The chain would be broken. The
11 supply chain, the consumers would not have what
12 they're looking for. So, I think they ultimately
13 have to be held responsible in that chain. Yes,
14 sir.

15 CHAIR REEVES: And then general views, of
16 the others with respect to that point. The end-user
17 sort of person being treated exactly like the main
18 distributor, who dumps 300 grams there to be
19 distributed by all others?

20 MR. T. WILLIAMSON: Yes, I think the
21 end-user, obviously we have to provide some
22 resources and, you know, that's obviously straining

1 on all of the communities. And, you know, the
2 states, and even all the way up to the federal level.

3 But, you know, I think the focus here needs
4 to be on the ones that are providing the poison to
5 the communities. I think they all, anywhere in that
6 line of event, or chain of events, all the way up
7 to the mass super labs, all the way down to the one
8 that's providing the poison to the communities, they
9 should all be handled harshly.

10 CHAIR REEVES: Thank you. Sergeant Kyle
11 Williamson.

12 MR. K. WILLIAMSON: Yes, I'm along the
13 same lines as these gentlemen. You know, everybody
14 has to be held accountable. And if, you know, if
15 you have a gram of ice, you're the end-user. Should
16 you be treated like the, you know, the head guy?

17 You know, not so much obviously there's different
18 -- there has to be different levels for the different
19 weights. And different enhancements, you know, for
20 different things.

21 You know, something we come across all the
22 time is kids are in the middle of this stuff. You

1 know, and there's enhancements for guns. And there
2 needs to be enhancements for kids. You know, if
3 they're armed and do this. You know, the criminal
4 histories obviously, let's be honest.

5 Every time these guys get arrested, they
6 get smarter, not dumber. You know what I mean.
7 So, they learn the system. They learn how to skirt
8 around it. They learn the loopholes, and things
9 like that. So, I think that has to be looked at
10 too and thrown into the matrix.

11 CHAIR REEVES: Thank you so much.
12 Commissioner Wong.

13 COMMISSIONER WONG: So, Sergeant Timothy
14 Williamson, you have mentioned how in Ohio, the
15 state penalty structure is such that it doesn't look
16 at purity, but it looks at quantity. And I'm
17 curious, Sergeant Kyle Williamson, and Special
18 Agent Delaney, if in Texas and Tennessee if it's
19 a similar kind of regime? Or if purity is part of
20 the state penalties for --

21 MR. K. WILLIAMSON: So, in Texas, so they
22 have straight possession. And then they have

1 possession with intent to deliver. So, there's --
2 but mainly it's along the same lines. Now purity
3 is not, our lab in Burke County won't even test for
4 purity. They just, the won't even do it. So, but,
5 no that's not the state law. Purity is not a state
6 law. It's just straight possession.

7 COMMISSIONER WONG: Uh-huh.

8 MR. DELANEY: That'd be the same answer
9 for the State of Tennessee. It's based off of
10 weight. I will add that our lab is in a unique
11 position, that we actually house a subsection of
12 the DEA lab at our regional lab, or headquarters'
13 lab in Nashville.

14 So, we kind of do a little bit of both.

15 They're just our employees from the DEA that work
16 literally across the hall from our drug
17 identification section that handles the state lab
18 side.

19 COMMISSIONER WONG: And given that, is
20 there a difference in all three of your
21 jurisdictions when it comes to testing practices?

22 When it comes to, you know, cases that get referred

1 to federal prosecutors versus state prosecutors?

2 Meaning, do you get labs back quicker for the state
3 charges because it's less essential whether -- or
4 can they rely on field tests, just indicating that
5 the mixture contained methamphetamine, or I'm just
6 curious if testing practices differ?

7 MR. T. WILLIAMSON: It's my experience
8 field tests really, the only -- it's the same thing
9 as what our lab will do. It's containment only.

10 A field test in our experience is, we wouldn't be
11 able to tell you what a purity level of the meth
12 would be, until we do get that final lab result.

13 But for us, it's a case-by-case basis.

14 We can receive labs a lot quicker than Ohio
15 sometimes on certain cases at the state level.
16 Where with DEA if we send those -- to get the lab
17 results from DEA, from the Columbus Office, we have
18 to ship those narcotics through Detroit, or I'm
19 sorry, Chicago to have them tested. And they can
20 be done quickly, but again, it depends on your
21 definition of quick, so.

22 COMMISSIONER WONG: I see. So, even if

1 they're local arrests that are referred to federal
2 prosecutors, they would always go through the DEA
3 labs?

4 MR. T. WILLIAMSON: Yes.

5 MR. K. WILLIAMSON: Yes. So, in Texas
6 where we're at, it's basically the same thing. If,
7 you know, our labs wouldn't do purity level. So,
8 we'd have to rely on our federal partners to send
9 to. You know, to a different lab.

10 CHAIR REEVES: VC Murray.

11 VICE CHAIR MURRAY: I wonder if you could
12 talk a little about the relative community harms
13 of meth versus other drugs. I thought it was very
14 interesting that there's a difference between the
15 rapid death of fentanyl and the slow death of meth.

16 You can imagine that having, you know, one rips
17 a thread out of the fabric of the community, another
18 kind of rots relationships.

19 And I wonder if you could talk about who
20 relies on and which method is unique or different
21 -- mean I don't know if the psychosis aspect plays
22 a hand, or what, relative violence. Just if you

1 have thoughts of things you've seen on that front?

2 Thanks.

3 MR. DELANEY: I'll be glad to answer that.

4 Obviously, with the extended use that a consumer
5 experiences with methamphetamine, that allows them
6 an extended period of time to commit additional
7 crimes to support their habits, right?

8 So, that's where you're looking at the
9 people inside their houses, going to be the victim
10 of their cash getting stolen out of their wallets
11 or out of their savings accounts at the banks. And
12 then after they've depleted those resources, they
13 extend on out into the community, extended family
14 members, right? And then the next thing, they're
15 going to be after complete strangers.

16 So, with that extended pattern of abuse,
17 gives them the opportunity to commit that extended
18 period of crime. Starting out like I said, petty
19 theft, and going all the way up until, to bank
20 robbery. You know, you'll see all kinds of it.
21 So, does that answer your question? Does that get
22 you in the general direction?

1 COMMISSIONER WONG: Yes.

2 MR. DELANEY: Yes, ma'am.

3 MR. K. WILLIAMSON: I'll just be very
4 frank, ma'am. I've dealt with a lot of people doing
5 a lot of different drugs, and these are by far the
6 most -- the people who have been using meth for a
7 while, are by far the most messed up in the head.

8 For lack of a better way to put it. They just,
9 it seems to have a worse effect than any other drug
10 in my opinion, from what I've observed.

11 And it, whether there's any coming back
12 from that once they get off the drug, if they get
13 off the drug, you know, I couldn't tell you. But
14 to me, it just almost seems like they're just
15 completely brain dead at some point. I don't know
16 if that helps, but that's been my experience with
17 the drug. It's just, it's a bad one.

18 CHAIR REEVES: VC Restrepo.

19 VICE CHAIR RESTREPO: I'm curious if from
20 the three different states here, have you, are you
21 familiar, even just anecdotally, with any effective
22 treatment protocols that are available to the

1 end-users in your particular states?

2 MR. DELANEY: I would say there's options
3 out there as far as community resources, support
4 personnel, and that type of thing. But ultimately,
5 at the end of the day, that consumer has that choice
6 to decide they want to quit. And they get that
7 support through the community resources, through
8 our Department of Mental Health and Substance Abuse.

9 There's the support system out there, but
10 to say there's one tried, true method, absolutely
11 not. No, sir.

12 CHAIR REEVES: Sergeant Kyle Williamson,
13 I want to follow up on what you said. You've
14 indicated that basically with the meth, you
15 basically have seen nothing like it, I think. I
16 may have sort of stretched your words a little bit.

17 That it's really something that you've seen, and,
18 you know, don't see.

19 I'm just wondering, I assume your law
20 enforcement career goes back to the crack-cocaine
21 epidemic. And people were saying, about how
22 horrendous crack was. And what it was doing, crack

1 babies, crack blowing your head up, just a whole
2 bunch of stuff, with respect to the, how it affected
3 individuals. How it made individuals go out and
4 be extraordinarily violent, the violence
5 associated.

6 If you were around then, how do you compare
7 the two?

8 MR. K. WILLIAMSON: I think this is
9 actually a lot bigger. I think it's reaching more
10 people, more communities. It seems to be affecting
11 everybody regardless of age, or demographic or, you
12 know, how much money you have. It seems to be
13 reaching a lot further. So, in that respects, it's
14 a lot worse. Thank you.

15 CHAIR REEVES: Gentlemen, thank you so
16 much for your testimony. We invite you to please
17 stay around for the rest of the hearing, after we
18 take our lunch break. We'll return in about an
19 hour, after our lunch break. Thank you so much.

20 You may turn off your livestream.

21 (Whereupon, the above-entitled matter
22 went off the record at 12:00 p.m. and resumed at

1 1:08 p.m.)

2 CHAIR REEVES: -- an addiction
3 neuropharmacologist who also serves as an adjunct
4 professor in the Department of Pharmacology in the
5 University of Texas Medical Branch. Second we have
6 Dr. John Mendelson, an internist who serves as Chief
7 Medical Officer of Ria Health and Clinical Professor
8 of Medicine at UC San Francisco.

9 Dr. De La Garza, sir, we're ready when you
10 are. Thank you.

11 DR. DE LA GARZA: Thank you, Chair Reeves,
12 and thank you to the Commission for the opportunity
13 to speak to you today.

14 Among my other titles I was -- I am the
15 past president of the College on the Problems of
16 Drug Dependence, also known as CPDD, the largest
17 and oldest scientific society dedicated to
18 addiction research in the country.

19 So I've been doing addiction research for
20 about 25 years. I have focused on cocaine,
21 methamphetamine, more recently opioids. We do
22 medications testing. We try to find new treatments

1 that might be helpful for individuals who are
2 addicted to methamphetamine.

3 What we do is bring people in from the
4 streets who are methamphetamine-dependent or meet
5 criteria for methamphetamine use disorder and we
6 evaluate them on several different levels. One of
7 them obviously is asking them some questions about
8 their current use of methamphetamine, how often
9 they're using it on a daily basis, how many years
10 they've been using it.

11 And we have learned, like many -- like
12 speakers before, Dr. Wagner in particular, that our
13 methamphetamine users aren't using methamphetamine
14 in a vacuum. They are using other drugs of abuse,
15 but you know, more interesting to me is that 90
16 percent of our methamphetamine users are cigarette
17 smokers. About 85 percent of the methamphetamine
18 users use marijuana, and about 50 percent of them
19 use alcohol, not to mention some of the other
20 substances that they try over time.

21 I'm interested in this conversation about
22 meth use because we do ask questions about how much

1 methamphetamine they're using. The one figure that
2 I honed in on for the 2024 report that was put out
3 by this Commission was figure 23 on page 39.

4 The street-level dealers have on average
5 about 118 grams of methamphetamine on them when
6 they're caught. Our individual users are not
7 dealers. They are the end user. On average they
8 self-report about -- using about one gram per day.

9 So it's a small amount of methamphetamine. They
10 use that several times a day. And I think that's
11 really interesting and important to know, that
12 they're not using it all in one shot and they're
13 not necessarily having access to a large amount of
14 methamphetamine. We've published papers showing
15 that the number of individuals who have access to
16 unrestricted methamphetamine is very, very, very
17 small.

18 So the conversation today is about purity
19 and whether or not the purity of the methamphetamine
20 matters. For our patients, the people who are
21 enrolled in our protocols, we find that they are
22 using from a unique source. They tend to go back

1 to their dealer every single time. Dr. Wagner
2 touched on this topic earlier and I would like to
3 echo the sentiment that they want to get their
4 methamphetamine from a source that they can trust
5 and they're not going around and shopping for
6 methamphetamine through different dealers that are
7 available out on the street.

8 It's probably not a surprise to you
9 individuals, but our patients have been in the
10 judicial system in one way or another and have been
11 incarcerated for various periods of time. None of
12 them want to go back. None of them want to be
13 arrested again. So they're going to do everything
14 they can to stay safe and to -- but unfortunately
15 they have to support their habit.

16 One of the ways that we interview our
17 patients and we talk to them about their
18 methamphetamine use is to actually expose them to
19 methamphetamine in the laboratory. The reason why
20 we do that is that we want to know whether or not
21 the medication that we're testing versus placebo
22 is safe in that population. Really important to

1 know if you ultimately want to approve a medication
2 for methamphetamine use disorder.

3 So we can give them IV methamphetamine or
4 another experience we've given them smoked
5 methamphetamine and we look at cardiovascular
6 effects and then subjective effects. And exactly
7 what you would expect they get high, they feel good
8 and they tell you how much they would pay for the
9 infusion they just received. So we know that
10 methamphetamine that we were giving in the
11 laboratory, even though it's a small quantity of
12 methamphetamine, is actually reinforcing they like
13 it. And so they're willing to take that.

14 We go further by having them
15 self-administer methamphetamine, opportunities to
16 self-infuse and/or smoke methamphetamine from a
17 pipe several different times separated by about 15
18 minutes for each of those infusions. It's a safe
19 environment. There's medical doctors around.
20 There are nurses around. There are all sorts of
21 clinicians who are there to make sure that they're
22 safe.

1 What's interesting to me and I think should
2 be interesting to you is that despite that -- and
3 it depends on the experiment that we've done, and
4 we've published all of this work -- if there are
5 10 infusions that are available of methamphetamine
6 versus saline, when saline is in the syringe they
7 don't self-administer. They'll take one or two
8 because they're trying to figure out if there --
9 is this the good stuff -- they call it their nope
10 -- or the good stuff, the dope.

11 When the methamphetamine is in the
12 syringe, they'll take some methamphetamine, but
13 they do not take all of the methamphetamine. And
14 I think that's profoundly interesting. They have
15 an opportunity to take all of it and nobody's going
16 to stop them, but they don't. The alternative is
17 money. So they have an opportunity to have a small
18 amount of money or take the methamphetamine
19 infusion. What they tend to do is try to get the
20 high that they're seeking and then that's good
21 enough.

22 So the purity argument I think is

1 interesting, but doesn't really apply to the end-
2 level user. All they want to do is to get that high.

3 And so if it's adulterated in some way or another,
4 they're not saying, well, this isn't good enough.

5 They'll just titrate a little bit above or below
6 if it's super pure. But do they know? Absolutely
7 not. And there's no way for them to test that
8 themselves. But we have tried to gain a perspective
9 on some of these issues for them.

10 I have quite a bit of experience in this
11 area. Again, we've been doing this work for about
12 15 -- well, about 20, 25 years. And our
13 participants, just so that you have a perspective,
14 tend to be Caucasian or White. They tend to be male.

15 They tend to be about 35 to 40 years of age, which
16 matches well with the table 4 on page 24 of the report
17 of the individuals who are caught trafficking
18 methamphetamine.

19 I think that the individuals that we see
20 in our laboratory that come in for these studies
21 are reflective of a lot of the end users of
22 methamphetamine, so I think it's useful to know a

1 little bit about how they come about to our
2 laboratory and participate in our studies.

3 I would be happy to answer any questions
4 that you have related to the report that I provided
5 or some of the remarks that I've given to you here.

6 CHAIR REEVES: Thank you so much.

7 Dr. Mendelson?

8 DR. MENDELSON: Yes, hi. I'm Dr. John
9 Mendelson. I'm an internist that trained at UCSF,
10 did quite a bit of NIDA-funded research in
11 methamphetamine and opiate pharmacology, my
12 background being human clinical pharmacology. I
13 now run a company that's dedicated to treated
14 alcohol use disorder, and we're scaled in all 50
15 states.

16 The research that's relevant that I've
17 done a lot of work in -- so is the other gentleman
18 you're going to hear from today. The research
19 that's most relevant to what you're discussing are
20 differences between the d and l methamphetamine
21 isomers in people. We've conducted studies looking
22 at how human beings respond to if you give them pure

1 d-methamphetamine, you give them pure
2 l-methamphetamine, or you give you mixtures of d
3 and l-methamphetamine. How do they perceive those
4 doses? And you're asking about mixtures and
5 dilutions. This is the most relevant research
6 you're going to hear from people today on that topic.

7 In general, if you give a person a dose
8 containing d-methamphetamine, they think it's
9 d-methamphetamine. And if you give them a dose that
10 contains only l-methamphetamine, they don't think
11 it's very good methamphetamine. You give them a
12 50/50 mixture, it's still d-methamphetamine. And
13 they will pay the same amount for a 50/50 mixture
14 as for a 100 percent at comparable doses. So
15 dilution of methamphetamine by the potency, the d
16 isomer, they -- I'm sorry, they l isomer does not
17 greatly affect the monetary value of a dose.
18 However, toxicity may be affected in ways we don't
19 yet understand.

20 The issue of which -- of the purity and
21 whether it's d or l is really relevant though to
22 the future. At the present -- we conducted our

1 research because of a change in precursors that was
2 going on, going from the phenyl-2-propanone to
3 ephedrine and to try to predict future toxicity
4 events.

5 This morning in testimony you heard that
6 the cost of methamphetamine has dropped
7 tremendously, and therefore -- and I now speak
8 business. I've now got the degree in how to speak
9 business and the cost of goods. So I ran a company.

10 I'm not just a scientist. You can bet your bottom
11 dollar that synthetic manufacturers, licit and
12 illicit, always look to lower the cost of goods and
13 increase their profit margins.

14 And if the price of your product has
15 dropped 90 percent, you're going to be looking for
16 cost-cutting measures. And if takes extra
17 synthetic steps to make pure d-methamphetamine, you
18 can bet that labs will begin to switch to precursors
19 that cost less money and yield racemics and other
20 potentially undesirable items.

21 So I do think it will still be relevant
22 to -- I will disagree with the DEA earlier saying

1 that isomer testing is not useful. I think it will
2 be very useful in the future because you're going
3 to see more methamphetamine on the street that's
4 a 50/50 mixture of d and l-methamphetamine just
5 because the starting materials are cheaper,
6 synthesis is easier. And if you have a
7 cost-effective product that's going to be something
8 people are going to do.

9 I think also you're going to see different
10 types of toxicity. And where you'll see less, that
11 the mixtures of d and l are less desired is when
12 the d-methamphetamine purity drops below 25
13 percent. Then you're going to see a decrease in
14 the value to the consumer of that dose.

15 Finally, I'm going to get -- this is not
16 part of my formal testimony, and I'm going to stray
17 a little here. And I thought about putting it in,
18 but it was not in the remit. But you've heard that
19 50 percent of all people who use methamphetamine
20 also use alcohol, co-administered. We published
21 papers on that many, many years ago showing that
22 the intoxication, the combination of

1 methamphetamine plus alcohol was greater than
2 methamphetamine alone or alcohol alone. The
3 duration of action was longer and people desired
4 it more.

5 And we haven't heard anything in the
6 criminal side of the combination of alcohol plus
7 methamphetamine. Alcohol dis-inhibits people,
8 produces more domestic violence, produces more car
9 crashes, produces more harm. So my bet -- and the
10 Commission might want to commission in your studies
11 like how many people were drinking at the time they
12 were arrested for their methamphetamine crime?
13 Right? How many people were intoxicated on alcohol
14 while also intoxicated on methamphetamine at the
15 time they were arrested?

16 This might be very useful information,
17 might be a way to separate those who are dealers,
18 who are unlikely to be drinking or maybe presumably
19 less likely to be drinking at the time of sale, from
20 users who are presumably more likely to be consuming
21 alcohol concomitantly with methamphetamine.

22 And so I'll leave you with an interesting

1 provocative area. Hope it's not too much of a
2 spanner in the works.

3 CHAIR REEVES: All right. Thank you,
4 gentlemen, for your opening statements.

5 Any questions from my colleagues? Yes,
6 VC Murray?

7 VICE PRESIDENT MURRAY: Thanks to both of
8 you. So why wouldn't racemic meth already be the
9 dominant form if it's cheaper to produce and give
10 you the same titrating? Would they be able to
11 titrate the racemic meth?

12 DR. MENDELSON: Well, obviously the
13 starting -- obviously they have an access to an
14 starting material if they can still produce a
15 penny-a-dose product, you know? But if access to
16 the starting material, wherever those laboratories
17 are that are synthesizing methamphetamine, if
18 there's more control of precursors in their
19 locality, they'll switch to a precursor that like
20 the old days was -- yields racemic methamphetamine.

21

22 And you saw on one of the graphs in there

1 -- it was really interesting. On one of the graphs
2 there was a drop in potency for a couple years there
3 I saw, down to like 60 percent for a while. So these
4 precursor changes are still active and going on.

5
6 Again, I don't manufacture drugs and I
7 don't know anything about the people who manufacture
8 drugs. I just know what the pharmacology is and
9 would suggest that racemic methamphetamine will be
10 very abusable so as long as there's a good enough
11 dose of d. You need a lot of d. l-methamphetamine
12 is not abusable. You can walk down the street and
13 buy l -- we could all walk down the street and buy
14 l-methamphetamine at Walgreen's, the Vick's nasal
15 inhalers, sitting right there.

16 VICE PRESIDENT MURRAY: Am I right --
17 sorry. I might be confusing potency and purity,
18 which I know is the cardinal sin, but if you had
19 a racemic specimen and it was tested for purity,
20 and it was a 50/50, it would come back as 100 meth?

21 DR. MENDELSON: Yes, it always comes --
22 that's something that was not emphasized that --

1 so again the atomic structures -- the same number
2 of atoms. Same number of constituents. Just the
3 handedness is different, right? So 100-percent
4 pure methamphetamine could be 100-percent
5 l-methamphetamine, which is what you can buy down
6 at the drug store.

7 VICE PRESIDENT MURRAY: Vick's would come
8 back as --

9 DR. MENDELSON: Would come back as pure,
10 right? So the chirality, the -- whether it's
11 left-handed or right-handed d or l ultimately does
12 matter. But in this issue of mixtures, once you're
13 at 50/50, it's the same as all d. Okay? At least
14 for value. And I've included the graph, some graphs
15 from our studies to support that.

16 CHAIR REEVES: VC Restrepo?

17 VICE PRESIDENT RESTREPO: Doctors, the
18 same question I had for Dr. Wagner: So aside from
19 working on the guidelines the Commission does a lot
20 of outreach, a lot of educational programming to
21 judges, prosecutors, defense attorneys, and really
22 probation officers. What should the message be and

1 what can we do --

2 DR. MENDELSON: Alcohol. I'm going to be
3 blunt about this. Alcohol. It should be ethanol.

4 You have 50 percent of the people co-administering
5 methamphetamine plus ethanol. It does produce a
6 bigger intoxication, lasts longer. Okay? That's
7 data from -- 1993 I think I published that. A really
8 long time ago. So it's like that -- and again it
9 doesn't get any discussion any place. So you want
10 to move the needle, talk about alcohol.

11 VICE PRESIDENT RESTREPO: Doctor?

12 DR. DE LA GARZA: I agree obviously with
13 the comment about other drugs of abuse, but I also
14 think -- I'll echo the remarks by Dr. Wagner earlier
15 that we have to continue to think of these as people
16 and not just these entities that are using
17 methamphetamine. They are incredibly human, the
18 ones that we have seen. We don't see them for brief
19 periods of time. We see them for weeks at a time.

20 And you learn a lot about them and the struggles
21 that they've been through.

22 What I think you can include in terms of

1 education and better preparing individuals who are
2 going to be in this field is understanding some of
3 the other factors that are contributing to their
4 journey towards addiction, and that includes some
5 of the impacts of homelessness and adverse childhood
6 experiences, and all of the other things that are
7 exacerbating their drug addiction profile. So I
8 think those are the things that I would encourage
9 you to include in the educational materials.

10 DR. MENDELSON: I think the final point
11 I might make on this is that methamphetamine
12 epidemics have occurred around the world for the
13 last 75 to 100 years. They always occur in a
14 background of people needing to work really hard
15 to earn a living. In Japan they very first
16 methamphetamine epidemic occurred after World War
17 II when there were very few well-paid jobs. People
18 needed two or three jobs.

19 This current epidemic is coming at a time
20 when working Americans like high school-educated
21 Americans have less opportunity, are paid less, and
22 are struggling tremendously. Rural communities

1 even more so. To work hard you need to stay awake.

2 To stay awake you need a stimulant. I should maybe
3 not -- I should be cautious here since I have a cup
4 of coffee next to me.

5 But this is a disease. This is a problem
6 of people who want to work, not people who don't
7 want to work. It's a problem for people who want
8 to work. They want to stay awake. They want to
9 focus. They want to do -- they need to do jobs that
10 require vigilance, attention, and being awake.
11 Okay? So I think that's another part you can go
12 to the education side here on, that like if you're
13 really -- like if you need to do something other,
14 we need to address people's lives so that they don't
15 need to have two or three jobs in order to make their
16 ends meet.

17 CHAIR REEVES: VC Mate?

18 VICE PRESIDENT MATE: Thank you, both, for
19 being with us today. I saw you here earlier, so
20 I appreciate your time with us today and your written
21 comments.

22 DR. MENDELSON: Well, it's a real

1 pleasure. It's really quite -- this is quite cool,
2 you know?

3 (Laughter.)

4 CHAIR REEVES: Oh, we haven't been
5 described as cool before. This is great.

6 (Laughter.)

7 CHAIR REEVES: Love you. Love you.

8 (Laughter.)

9 VICE PRESIDENT MATE: Stay all day,
10 please. I just wanted to follow up and make sure
11 I understand your point about alcohol in connection
12 with this. We hear concerns about sort of the
13 conduct of individuals when they're using
14 methamphetamine. And it is your encouragement to
15 us that we like examine whether -- when we're looking
16 at that to raise the question of whether it's like
17 a function of the methamphetamine or whether other
18 --

19 (Simultaneous speaking.)

20 DR. MENDELSON: I think it's the
21 interaction between methamphetamine and alcohol.

22 As I understand it, 30 percent of all people who

1 are incarcerated did their crime while they were
2 drinking, right? It's the unaddressed elephant in
3 the room across criminal justice, right? And you
4 add a stimulant to someone highly intoxicated on
5 alcohol, like a .1 BAC or above, and put some
6 domestic violence in there, you've got a real
7 problem. You've got a real problem, you know? And
8 those people I'm sure look terrible, you know? And
9 it's 50 percent of the meth-using population, which
10 is growing because people need to work. Okay?
11 They're already drinking. Again, I think this
12 would be a very fertile area for criminal justice
13 to ask are you -- and we have a lot of treatments
14 for alcohol right now. We can make progress on
15 that. We had some for methamphetamine. Dr.
16 Shoptaw will talk about those. But alcohol is
17 imminently addressable. Okay?

18 CHAIR REEVES: Did you have another
19 question?

20 VICE PRESIDENT MACE: Oh, I do have
21 another question but I wasn't going to hog --
22 (laughter.)

1 CHAIR REEVES: I just a couple of
2 questions. What I've heard earlier today about
3 there may be no pharmacological differences between
4 the meth purity and whatever else -- then how does
5 the Commission justify, if you will, or can we
6 justify the 10 to 1 ratio that we use in sentencing
7 people for actual methamphetamine versus a
8 mixture?

9 DR. DE LA GARZA: Yes, I'm going to agree
10 with the previous panel members and say that I think
11 it's a mistake to do that because our
12 methamphetamine users, when they go out on the
13 street are just buying methamphetamine. They're
14 not thinking about the purity of the sample or not.

15 And so I don't know that that is helpful ultimately
16 for the Sentencing Commission to continue to go down
17 that path. So I think I would have to agree with
18 what was said previously.

19 CHAIR REEVES: And I want to follow up on
20 what I heard you -- one of you say earlier. And
21 I heard many people talk about the user going to
22 a trusted source. And I think that's been

1 emphasized with respect to meth addiction, but with
2 your dealings with other types of addiction, whether
3 it was cocaine, marijuana, or whatever it is, don't
4 people go to their -- I'm just --

5 DR. DE LA GARZA: Oh, yes.

6 CHAIR REEVES: -- I mean, their source,
7 their trusted source?

8 DR. DE LA GARZA: That's right. The
9 behavior is exactly the same.

10 CHAIR REEVES: Okay.

11 DR. DE LA GARZA: We've done a lot of
12 studies on cocaine-addicted individuals. Exactly
13 the same sort of behavior. They have their trusted
14 vendor, as it were.

15 CHAIR REEVES: Yes.

16 DR. DE LA GARZA: And that's who they go
17 to, and they buy that product from them. And so
18 I think that's a pretty common behavior.

19 CHAIR REEVES: And there's no distinction
20 between meth and any other sort of drug? People
21 go to --

22 DR. DE LA GARZA: Oh, yes.

1 CHAIR REEVES: Okay.

2 DR. DE LA GARZA: I think that's the same.

3 DR. MENDELSON: So in another part of my
4 life I helped develop buprenorphine-naloxone
5 combinations, which are sold as Suboxone, which is
6 a treatment for opiate dependence. And I ran opiate
7 treatment programs. Our lab was actually was an
8 opiate treatment program. People used to come down
9 and -- and it was kind of wild.

10 But you know, the answer is I think that
11 the penalty -- we're not -- you don't have a
12 differential penalty for heroin versus fentanyl
13 right now, I think. Right? A 10 to 1 ratio? I
14 think the ratio is just punitive.

15 And it's up to you guys. I mean, I don't
16 favor punitive solutions to many things, unless they
17 personally affect me. But, no. (Laughter.) I
18 don't favor punitive solutions to many things, even
19 if they do affect me. But it doesn't seem
20 justified. Looking at those numbers for the
21 amounts of methamphetamine used for people
22 basically trying to work most of the time seem

1 excessive. And I think I would try to get them down
2 to some lower number. Does it really make -- does
3 10 years really make a difference for someone who
4 is like again trying to drive a truck?

5 I think it's a -- and the violent --
6 obviously if there's violent crime, if there's other
7 factors, and possibly if there's drinking while
8 using lots of methamphetamine, which could endanger
9 people while driving, increase more accidents,
10 increase more fights, I think that could be useful.

11 But just a stand-alone on the amount of impurity
12 does not seem to be well-justified.

13 CHAIR REEVES: Commissioner Wong?

14 COMMISSIONER WONG: Thank you. You
15 talked about, Dr. Mendelson, the interaction
16 between alcohol, but I think, Dr. De La Garza, you
17 had talked about like 90 percent of meth users are
18 smokers. And it was 85 percent who smoked
19 marijuana?

20 DR. DE LA GARZA: Consumed marijuana,
21 cannabinoids.

22 COMMISSIONER WONG: I mean those are even

1 higher correlations. Are there interactions there
2 or what may or may not explain?

3 DR. DE LA GARZA: Well, so the interaction
4 would be just the opposite, right? So you might
5 have some suppressant effects when using marijuana.

6 So and the nicotine I don't necessarily think
7 there's any accentuation of the high. We published
8 a paper maybe 10 years ago showing no real
9 differences between cigarette smokers and
10 non-cigarette smokers in the high that's produced
11 by cocaine and methamphetamine. So I don't think
12 nicotine is going to be part of this kind of formula,
13 but I think it would be interesting to learn more
14 about the concurrent use of cannabinoids of various
15 sorts and what impact it might have on some of these
16 outputs.

17 DR. MENDELSON: And particularly on
18 psychosis, I mean the cannabinoid-methamphetamine
19 work needs to be done. Has not been done yet.
20 There's recent concern -- I mean, cannabinoids are
21 now legal most states and higher-dose, high-potency
22 cannabinoids are going to produce something that's

1 not good, but we don't what it is yet. Okay?

2 COMMISSIONER WONG: K2 and --

3 DR. DE LA GARZA: Well, not even K2, but
4 that's certainly going to be a big issue. But
5 adolescent use of cannabinoids is certainly
6 associated with higher instances of psychosis and
7 other mental health kind of issues. And I think
8 when you factor that in as a possibility of maybe
9 making these individuals more susceptible to when
10 they use a methamphetamine chronically or
11 repeatedly over time, which in itself has been
12 associated with increased incidences of psychosis,
13 I think that's an interesting kind of dilemma.

14 DR. MENDELSON: Exactly.

15 DR. DE LA GARZA: We'd have to consider
16 --

17 DR. MENDELSON: Yes, we don't have data
18 yet.

19 DR. DE LA GARZA: We don't have that data.

20 DR. MENDELSON: That's we'll see you in
21 10 years.

22 CHAIR REEVES: All right. Oh, I'm sorry.

1 Yes, yes. Go ahead.

2 COMMISSIONER WONG: No, that's okay.

3 Just one more question. I was thinking earlier --
4 with an earlier panel we were talking about the abuse
5 potential for methamphetamine as compared to other
6 substances. And there was some suggestion that
7 maybe the abuse potential is similar to cocaine.

8 Do you have any sort of thoughts on -- like if you
9 were trying -- we have this table where we're
10 comparing --

11 DR. MENDELSON: Why don't you go first?

12 COMMISSIONER WONG: -- different
13 substances.

14 DR. DE LA GARZA: Well, the only report
15 that I'm aware of that compared the various drugs,
16 drug classes is one by Jim Anthony, a colleague of
17 ours, that was published many, many years ago. So
18 I don't know to what extent that is still valid
19 because methamphetamine has changed over time,
20 cocaine has changed over time. But I do think that
21 there are differences between these drug classes.

22

1 We published a paper in 2010 showing the
2 acute cardiovascular and subjective effect
3 differences between cocaine and methamphetamine in
4 a controlled environment. I think those are really
5 interesting. But in terms of abuse liability I'm
6 not entirely sure what the newest data would look
7 like.

8 DR. MENDELSON: Yes, I don't think there's
9 any good modern data on this, modern meaning the
10 last 10 years. Drugs tend to find populations of
11 people who like them. Like people have
12 preferences, except maybe for alcohol again, which
13 seems to cut across all of them. And I think you
14 also have to look at the social context that the
15 drugs are being used at.

16 The cocaine epidemic occurred in a time
17 of lots of partying, lots of wealth, right? The
18 amphetamine epidemics occur in times of relative
19 poverty and the need to work hard. And that's why
20 I think we're seeing the use skyrocket right now
21 is because this is a really tough time for working
22 Americans. And you're going to see a lot more cases

1 over the next five years. I mean, this is the drug
2 of abuse to bet on for the next few years.

3 So I think finding some equitable way to
4 address whether people are working, what their real
5 -- their motivations for use are. If their
6 motivations for use are just to get high, to have
7 more sex, you know, not such a -- maybe not so legit.

8 But if their motivation is this is the third job,
9 that they have to work that third shift in order
10 to pay the rent, I'd be a little more unhappy about
11 sending that person away for a long time.

12 DR. DE LA GARZA: I will say that one of
13 the metrics that is used very commonly in our field
14 is the self-administration model because that tells
15 you something about the abuse liability of a
16 substance. How willing, how hard is a person
17 willing to work to continue to self-administer that
18 substance? Will they do so despite adverse
19 consequences? And so cocaine and methamphetamine
20 are almost identical in that regard. People will
21 absolutely self-administer and they will continue
22 to do so even if it becomes increasingly more

1 difficult for them to get access to it. So we know
2 that these drugs are powerfully reinforcing.

3 I want to put a little plug in for animal
4 research because I used to be an animal researcher
5 in a previous lifetime. The reason why I think it's
6 important is you have not yet lived if you have not
7 seen an animal self-administering a drug of abuse.

8 DR. MENDELSON: Yes.

9 DR. DE LA GARZA: It is really powerful
10 to watch because here is an animal who has not been
11 experiencing homelessness, is not being sought
12 after by the criminal justice system, and yet
13 they're in there self-administering the drug. And
14 the reason why that they're doing that is it's
15 powerfully reinforcing. No one's twisting their
16 little paws to say get in there and push the lever.

17 They are doing so because the drug is reinforcing.

18 Well guess what, our patients, the people that we
19 see on the streets are doing the same thing.

20 And then it's compounded by the fact that
21 they are experiencing homelessness, that they are
22 exposed to all sorts of levels of aggression and

1 violence. All of these things are really impacting
2 them. And that's why I made the suggestion to you
3 that if you were to improve the education efforts
4 that you target some of that as a way of better
5 understanding why people keep doing it, why they
6 keep going back.

7 DR. MENDELSON: Motivation.

8 DR. DE LA GARZA: But make no mistake, the
9 drugs themselves are powerfully reinforcing.

10 DR. MENDELSON: Yes.

11 CHAIR REEVES: Yes, go ahead,
12 Commissioner Meisler?

13 COMMISSIONER MEISLER: Just to close the
14 loop on some of your observations, Dr. Mendelson,
15 about methamphetamine consumption, I didn't see in
16 your written research summary findings or the 2006
17 and 2008 studies that were appended to it -- I didn't
18 see -- maybe I just missed this -- kind of empirical
19 research into people consuming methamphetamine
20 illicitly to stay awake on their jobs. Is there
21 somewhere we should look to kind of verify that?

22 DR. MENDELSON: It's not research I've

1 conducted myself. It's an observation that sort
2 of is potent across the -- people who think about
3 epidemics and waves of addictions, right? Because
4 they come and go. And why do they come and go?
5 But certainly in the military the reason people are
6 given amphetamines, like pilots, is to stay awake
7 and stay focused, right? I mean, okay?

8 COMMISSIONER MEISLER: I'm just trying to
9 figure out if --

10 DR. MENDELSON: I mean, we have jobs data
11 from the U.S. Department of Defense where they would
12 rather have a guy flying his F-15 on an amphetamine
13 than not.

14 COMMISSIONER MEISLER: Right. I guess
15 I'm just trying to think about it from the opposite
16 end of the spectrum, right?

17 DR. MENDELSON: Yes.

18 COMMISSIONER MEISLER: The people who are
19 trying -- who are seeking drugs through illicit
20 sources and if they're doing so for purposes of
21 maintaining employment. I just wasn't aware that
22 --

1 (Simultaneous speaking.)

2 DR. MENDELSON: Yes, yes. Yes, I think
3 the most relevant material comes from the first
4 Dexedrine epidemics in the '50s with truck drivers
5 who were -- and we have a bunch of rules as a result
6 of that. You can only drive eight years. you know,
7 you have a shift on truck driving.

8 And it's no accident by the way that
9 Arkansas is still in the middle of the amphetamine
10 epidemics, right, at 50 -- 70 years later. Arkansas
11 was the truck driving capital of the United States
12 in the 1950s. Long haul drivers went both ways.

13 Why is Walmart there? And you have -- what
14 requires more vigilance and attention than driving
15 a large truck at night on the freeway, or before
16 freeways, on U.S. 66?

17 So I think the amphetamines have always
18 been used in all contexts where they've been talked
19 about across time as things to enhance your
20 vigilance, enhance your ability to stay awake, and
21 stay focused. And again, the military uses them
22 for that purpose today.

1 COMMISSIONER MEISLER: Thanks for your
2 answer.

3 CHAIR REEVES: Yes?

4 VICE PRESIDENT MURRAY: And so what's your
5 sense of why people are in your estimation seeking
6 out illegal methamphetamines rather than legal
7 amphetamines like Adderall?

8 DR. MENDELSON: Cost.

9 VICE PRESIDENT MURRAY: You hear about
10 Adderall.

11 DR. MENDELSON: Well, you know, we doctors
12 are expensive. We charge people just to talk to
13 them about it, you know so -- right? So it's a lot
14 cheaper to get the guy on the corner.

15 And it was telling that -- I don't know
16 how the other panelists feel about it, but that
17 they're stamping -- they're making fake Adderall
18 out of methamphetamine. It means Adderall is
19 expensive and hard to get.

20 VICE PRESIDENT MURRAY: Dr. De La Garza,
21 I was wondering if -- we were talking a little bit
22 about whether there are pharmacological -- and I

1 realize this is more -- I don't know, the word
2 experiential, but differences between high-purity
3 and low-purity meth. And I was struck in your table
4 -- you have this table about marijuana then versus
5 now and meth then versus now. The one difference
6 in the low-purity meth and the high-purity meth I
7 was struck at was the health impact trends. And
8 it looks like what the chart says is the high-purity
9 meth has more severe psychosis overdose and rapid
10 deterioration.

11 DR. DE LA GARZA: Yes, and so with the
12 caveat that what I said earlier about unrestricted
13 access to methamphetamine. On a purely
14 hypothetical basis, yes, if you had unrestricted
15 access to methamphetamine, you could do great harm
16 to the individual. But it's a simple economics sort
17 of issue. Most people don't have unlimited access
18 to methamphetamine. In fact, they can only afford
19 to buy enough methamphetamine for themselves for
20 half a day, or maybe a full day at the most. So
21 they're really not going to get that point.

22 I really appreciated the analogy earlier

1 to a long-distance runner versus a sprinter. I was
2 a long-distance runner in college. And so I like
3 that analogy. Over time you will cause significant
4 damage in a methamphetamine user, but it's the
5 presence of the adulterants that really complicates
6 the issue for methamphetamine use, especially the
7 opioids. And I think you can get toxicity and death
8 very quickly.

9 CHAIR REEVES: One final question: And
10 I think both of you -- at least De La Garza, I think
11 you've been here most of the day. Maybe both of
12 you have and you've heard -- what is one piece of
13 advice you would leave us with as we consider this
14 -- all of the testimony that we heard? What is the
15 one thing that comes to your mind that you want to
16 tell us to do?

17 DR. MENDELSON: Well again, I think
18 looking at the totality of the crime is going to
19 be really useful. I mean, the police departments
20 are -- the officers are struck with an unenviable
21 task of taking care -- taking people into custody
22 who are doing bad things and often had bad behavior

1 as well, right? But I think understanding the
2 totality of the circumstances would I think really
3 help at least put -- make the sentencing
4 recommendations more humane.

5 And at this point I don't think there's
6 much of a justification for again like separating
7 the ice, the crystalline, more crystalline
8 methamphetamine forms from non-crystalline
9 methamphetamine forms. I do think there's a value
10 in making sure that you don't have predominantly
11 l-methamphetamine in the seized sample.

12 But I think education. I think like
13 really -- we in the drug abuse community would love
14 to be more -- to give more education. For many years
15 I don't think even you guys did -- any of you guys
16 did this. NIDA had a program where -- TV shows
17 -- in TV shows the detective seizes a bag of
18 something, takes a switchblade out of his pocket,
19 always a switch -- back pocket, punctures it, puts
20 his little pinky in and tastes pure meth or pure
21 heroin, right? How many people have seen that?
22 Who hasn't seen that? Because you haven't been to

1 a movie. Well, they should die, right? Like if
2 it's fentanyl especially the guy should -- he should
3 be dead in five minutes.

4 So NIDA had this whole program where they
5 asked a bunch of us to work for free to advise movie
6 studios on what to write about drugs. And so I did
7 CSI for like 10 years. So all the scientific
8 misinformation in CSI belongs to me. But you know
9 what? But like it was a great adventure though
10 because like the people would call and say what is
11 going on here, or how do I say this?

12 And you guys should set something up with
13 us drug abuse experts, right? You know, a judge
14 has got a question. Reach out. Get expert advice,
15 right? Get expert advice. We don't need to know
16 anything about the case, right? It could be
17 completely anonymous in that sense. And that might
18 be something that would really be helpful because
19 we also don't hear about -- we hear the stories of
20 the people who are successfully coping with drugs.
21 We don't hear the stories of people who have
22 committed a crime, beaten someone up, have stabbed

1 or murdered someone. They're in jail. So they're
2 not the people going to Dr. Wagner's program, right?

3 So we don't get the other side of the story either.

4 We each do part of the elephant.

5 So that would actually be a fruitful
6 adventure would be to -- like let's actually have
7 like a -- in my company we do rounds every week.

8 We talk about the difficult cases. Should do
9 rounds, right? Present a case. Get the story.
10 Get some advice. Get some experts. Right?

11 That would be informative for all of us and
12 would help guide some of our like scientific
13 research as well as tailoring what we need to do
14 to better prevent these more severe criminal justice
15 outcomes because no one in our side of the street
16 targets any of that, right? I mean, none of us --
17 I've never -- I've tried to do studies with
18 prisoners. We've been blocked at every step. It's
19 very complicated.

20 CHAIR REEVES: Dr. De La Garza?

21 DR. DE LA GARZA: The only thing I'll do
22 is echo one of the sentiments that was made earlier

1 about the amount of methamphetamine that
2 individuals are caught with. Because I had
3 mentioned that our users self-report using one gram
4 per day, I agree with Dr. Wagner that five grams
5 per day is not a big step from there.

6 DR. MENDELSON: Yes.

7 DR. DE LA GARZA: And it does not
8 necessarily translate into some who's a dealer of
9 any sort. Certainly not a high-level dealer or
10 distributor, but not even a street-level dealer.

11 I mean, it's an inconsequential amount. I'll
12 again refer to figure 23 on page 39. The
13 street-level dealers had about 118 grams on them.

14 So I think that if we're talking about numbers like
15 5 or 15, even 50 grams, we're not talking about a
16 high-level dealer. So I would just be mindful of
17 that in terms of trying to distinguish among these
18 end users versus the ones that are maybe more
19 culpable at the very top of the chain.

20 DR. MENDELSON: So what you're saying is
21 everyone shops at Costco. That's what you're
22 saying.

1 DR. DE LA GARZA: Well, maybe.

2 DR. MENDELSON: Yes.

3 CHAIR REEVES: Well, gentlemen, thank you
4 so much for your testimony. We appreciate you.

5 Our next panel will provide us with medical
6 and public health perspectives on this issue.

7 First we have Dr. Steven Shoptaw, who serves as
8 director for the Center of Behavioral and Addiction
9 Medicine. He's a professor in family medicine and
10 psychiatry and biobehavioral sciences and a vice
11 chair for the research in family medicine at UCLA
12 Family Health Center.

13 Second, we have Dr. Gavin Bart, who serves
14 as a professor of medicine at the University of
15 Minnesota and director of the Division of Addiction
16 Medicine at the Hennepin Health Care.

17 Finally, we have Rear Admiral Dr.
18 Christopher Jones, who serves as Director of the
19 Center for Substance Abuse Prevention, and is Acting
20 Director of the Center for Behavioral Health
21 Statistics and Quality at the Substance Abuse and
22 Mental Health Services Administration.

1 Dr. Shoptaw, please, sir, we're ready when
2 you are.

3 DR. SHOPTAW: Chair Reeves and
4 Commissioners, thanks for the opportunity to talk
5 with you today.

6 My name is Steve Shoptaw. I'm in family
7 medicine. I'm a clinical psychologist, and I've
8 made my career over the past 30 years to develop
9 behavioral and medical treatments for
10 methamphetamine use disorder primarily.

11 My group and my teams have led the
12 investigation on contingency management, which is
13 now a standard of care.

14 And, we have three medications late in the
15 approval process for methamphetamine use coming off
16 the shelf, hopefully within the next 18-24 months.

17 So, there's a lot of reason to be hopeful.

18 I will say starting out, that there are
19 a few published reports that link medical, social,
20 psychological, dental consequences from
21 methamphetamine use, with type of methamphetamine
22 used.

1 You've heard consistent evidence this
2 morning that actual or mixture, or ice, really
3 doesn't matter.

4 It's an important dose related issue of
5 acute effects, but in terms of looking for negative
6 medical and sustained effects on these other
7 factors, it's not that important.

8 Across medical, epidemiological and
9 clinical studies, the health consequences due to
10 methamphetamine use, are instead due to repeated
11 high dose exposure to methamphetamine over time.

12 Repeated high dose exposure to
13 methamphetamine over time.

14 There's some models for this. In nicotine
15 and cigarette smoking, we know that behavior of
16 cigarette smokers are stable over time.

17 They dose a certain amount every day.
18 That amount of dosing occurs over addiction career.

19 Our data that I'll present today, actually
20 shows that this same thing can be found among people
21 who use methamphetamine.

22 It's important because in cigarette

1 smoking, we regularly use the concept of pack years
2 as a risk measure.

3 So if you're looking for a risk measure
4 for methamphetamine negative consequences, sort of
5 looking at frequency over a period of time, maybe
6 a year or six months, is a good marker.

7 So, the one milligram, the one gram of dose
8 that's pretty frequent -- common, and there's data
9 in my report and it's consistent with what was in
10 the prior presentation about daily dosing of
11 methamphetamine corresponds, the first, metabolism
12 of methamphetamine, the first pass, takes off a
13 methyl group and you have pure D-amphetamine.

14 Okay, so you start with methamphetamine
15 and then you go to D-amphetamine. So you're not
16 getting one drug or the other, you're going to pass
17 through amphetamine to get the drug out of the body.

18 So, one gram of methamphetamine contrasts
19 with the approved use of methamphetamine, which is
20 about 20-30 milligrams per day, for obesity
21 treatment.

22 It's a second-line treatment for obesity.

1 It is marketed in this country, as well as a
2 second-line treatment for childhood ADHD.

3 So, we're talking about dose here. That
4 is acute. Glen Hanson, the prior NIDA director has
5 models that show that when you take pre-clinical
6 animals and you give them low dose amphetamine, or
7 methamphetamine, what you get is not much. So, the
8 animal doesn't do much and you can't see any
9 neurotoxicity.

10 But if you give them high dose
11 methamphetamine, what happens is this high dose
12 methamphetamine moves dopamine out of vesicles,
13 storage vesicles in the nerve cells, and actually
14 causes the nerve cell damage that we see with
15 sustained high dose use of methamphetamine.

16 So, I'm getting to this point that it's
17 not just about the dose, but it's going to be about
18 the frequency of dose.

19 We see that acutely, this high dose
20 methamphetamine, it starts a process of
21 inflammation both within the gut, and also in the
22 circulatory system.

1 That actually is the major mechanism
2 thought of the underlying development of negative
3 health consequences of cardiovascular disease,
4 pulmonary disease, neuropsychiatric disease, and
5 dental disease.

6 So, what happens really? One of the
7 questions we've been struggling with here today is,
8 how do people use methamphetamine?

9 Our group has a cohort. We followed
10 people over the past 11 years and what we, we
11 captured behavioral data and urine data, and
12 physical health data from them in six month panels.

13 What we found is that we have three
14 reliable every six month phenotypes. We have
15 people who don't use methamphetamine, people who
16 use methamphetamine daily, people who use
17 methamphetamine as like a less than weekly basis.

18 So, we call these weekend warriors. We
19 call these guys daily users, and the non-users.

20 Comparing the people who are using daily
21 to people who are the weekend warriors, we see
22 significant benefit to less frequent

1 methamphetamine use over six month periods, along
2 whether they have a positive bacterial test for
3 sexually transmitted infections, detectable viral
4 load for people living with HIV, renal conditions,
5 neurological conditions, psychological conditions.

6 And in terms of social adversity, we see
7 benefits for using less frequently using
8 methamphetamine for unemployment, housing
9 instability, having ever been incarcerated,
10 experiencing intimate partner violence.

11 And, we also see that reduction from daily
12 use to a weekend warrior, seems to have some health
13 benefit that's correlational. It's not a
14 controlled study, but it's a strong linkage.

15 So, one of the benefits of using less is
16 you will see less physical health and social
17 adversity consequences.

18 We see in terms of looking at this
19 concentration of use, in looking at data from the
20 national household survey, we see that
21 methamphetamine dependence diagnoses increased
22 from the periods of like 2015 to 2020, something

1 like that.

2 And in fact, there are authors on the team
3 here who have written about this.

4 And so, what we saw was corresponding
5 increases in patient hospitalizations during that
6 same period for stimulant dependence.

7 So, these are correlational data, but show
8 that if you have a national level of concentrated
9 methamphetamine use, you also see a higher level
10 of reported myocardial infarctions in the hospital,
11 over the same period.

12 But we also see, we see the same sort of
13 thing happening for pulmonary disease. There's
14 something called pulmonary arterial hypertension
15 and it's a rare disease, and you die from it.

16 One of the places where you will see a
17 scientific report on mixture was from the 1993
18 report from a trucker in California, who was doing
19 crank.

20 He was snorting crank to be able to run
21 his trucks. And, he developed Pulmonary Arterial
22 Hypertension.

1 Today, methamphetamine is one of the
2 critical factors that you use to diagnose
3 methamphetamine idiopathic Pulmonary Arterial
4 Hypertension.

5 Again, a panel member plotted publicly
6 funded treatments for methamphetamine use disorder,
7 by geography.

8 And, the Pulmonary Arterial Hypertension
9 people plotted the cases of that disease nationally.

10 And, when you look at those charts, and
11 you can see that in my report, they overlie perfectly
12 with the highest prevalence of both conditions in
13 the West, followed by the South, the Midwest, and
14 then the Northeast.

15 Or it goes the Midwest, South, and
16 Northeast.

17 So again, correlational data but again,
18 more data showing that lung disease is linked not
19 to a dose, but to the frequency of the drug use.

20 And, I'll leave you with thoughts about
21 neuropsychiatric disease. The primary problem
22 from using meth frequently is stroke.

1 We heard that this morning, and it is
2 absolutely the case. That's a cardiovascular
3 problem that hits the brain.

4 But we also see other things going on as
5 well. We also see a degradation of the area of the
6 brain that inhibits impulses.

7 So we've been talking a lot about violence.

8 And in fact, I've done some expert testimony on
9 death penalty cases about methamphetamine being a
10 contributory factor to what happened in the event
11 of the violence.

12 If you talk to any of my patients, what
13 you'll hear them say is that when I'm on
14 methamphetamine, I've got no brakes.

15 So, if you're going down a road and you
16 actually have methamphetamine onboard, and that
17 methamphetamine involves violence, or the road
18 involves violence, there's no brakes.

19 And, I have some personal data on that in
20 terms of some consultations I've done that are very
21 interesting.

22 So, I always tell people methamphetamine

1 doesn't kill people, but people who use
2 methamphetamine kill people.

3 So it's just not that methamphetamine
4 causes violence, it is eroding the area of the brain
5 that actually is the brakes that helps people stop
6 doing heinous things.

7 There was some discussion today about
8 paranoid schizophrenia. One of the things about
9 paranoia schizophrenia that's very interesting I
10 think, is that abstinence doesn't bring you back
11 to today where I'm not paranoid.

12 So, this is a significant lifelong problem
13 again showing the disease in brains.

14 And I'll close with the idea about dental.

15 Dental, the inflammation that's caused by
16 methamphetamine, also affects the gingiva.

17 Every one of us hates going and seeing the
18 dental hygienist every six months, but it actually
19 saves our teeth.

20 And so, the idea of actually when you have
21 meth mouth, this decaying fractured teeth, you can't
22 get a job, which is a contributing factor.

1 It sets a limit on how far you can go into
2 returning back to where you were in society, before
3 you left.

4 So I'll summarize by saying, there are few
5 to no data showing negative correlations between
6 any negative medical/social/psychological
7 consequences and type of methamphetamine used.

8 Instead, it's strongly and consistently
9 correlated with the frequency of that dose used.

10 CHAIR REEVES: Thank you, Dr. Shoptaw.

11 Dr. Bart?

12 DR. BART: Thank you, Chair Reeves and
13 Commissioners. I'm pleased to be here.

14 I am an internist addiction medicine
15 physician and clinical pharmacologist, working out
16 of Hennepin Healthcare, which is Minnesota's
17 largest safety net health care system.

18 I'll read my comments extracted from my
19 written testimony.

20 So, we're 800,000 overdoses into our
21 opioid crisis since 2015 and it's garnered
22 incredible public attention.

1 But during this time, the rate of
2 methamphetamine associated overdoses has increased
3 nearly 8-fold with little public awareness, or
4 concern.

5 There are parallel increases in
6 methamphetamine associated hospitalizations,
7 emergency department encounters, and non-fatal
8 overdoses.

9 Last year, 2.4 million people 12 and older
10 in the United States, used methamphetamine with
11 two-thirds of them meeting diagnostic criteria for
12 methamphetamine use disorder.

13 In recent reports, overdose deaths due to
14 the combination of opioids and stimulants such as
15 methamphetamine, have surpassed overdoses due to
16 opioids alone.

17 Some refer to this increase as the fourth
18 wave of the opioid crisis.

19 Compared to those who use opioids only or
20 methamphetamine only, those who use opioids and
21 methamphetamine are more likely to be hospitalized,
22 engaged in emergency department visits, have

1 unstable housing, rely on public assistance, and
2 to be incarcerated.

3 And so, what this latter issues are more
4 reflective of how our society responds to people
5 who use drugs, the aforementioned medical
6 consequences methamphetamine use such as psychosis,
7 cardiomyopathy, lung disease, infections related
8 to injection drug use, sexual encounters, trauma,
9 and premature labor, are resource intensive,
10 expensive, and contribute to an unhealthy populous.

11 In short, methamphetamine is a major
12 public health issue.

13 Something that hasn't been mentioned today
14 is the public health implications of incarceration.

15 And, that's relevant to the U.S. Sentencing
16 Guidelines.

17 So, mortality rates during the first few
18 weeks following release from prison, are 14 times
19 higher than the general population.

20 While all-cause mortality has increased
21 following release, the main reasons for this
22 increase in mortality are driven by overdose,

1 suicide, and trauma.

2 The length of incarceration also impacts
3 post-release mortality, with one study showing
4 parolees experiencing a two year decrease in life
5 expectancy for every year imprisoned.

6 Contributing to these factors are
7 certainly pre-existing medical conditions,
8 undiagnosed or under treated medical conditions
9 during incarceration, the loss of benefits while
10 incarcerated, the difficulty reestablishing
11 benefits, and medical care upon release.

12 We heard about the difference between L-
13 and D-methamphetamine and so, a gram of pure DL or
14 racemic methadone, may be less potent than a gram
15 of pure d-amphetamine, they both seem to be
16 synonymous under the U.S. Sentencing Guidelines as
17 methamphetamine actual, or ice respectively.

18 Yet most testing seems to be based only
19 on the potency, and not -- on purity and not the
20 potency of how much of it is D- versus L-.

21 So I think if there's going to be a
22 sentencing standard based on purity, it may be

1 prudent to also account for differences in potency,
2 because methamphetamine actual is not necessarily
3 the same as ice.

4 But if here, is the main operational word
5 for two reasons. First, it's unclear from a
6 pharmacologic basis why methamphetamine is the only
7 commonly used drug for which purity enters the
8 Sentencing Guidelines.

9 With the advent of pure and potent
10 methamphetamine, those with existing tolerance will
11 just titrate their dose to the desired effect.

12 And, a person who is used to using
13 methamphetamine that might be racemic, if there's
14 a switch to the D- only, they aren't going to feel
15 as huge of a difference from that as someone who
16 has maybe never used any amphetamine at all. They'll
17 just simply use a smaller amount.

18 So, a gram of racemic doesn't go quite as
19 far as a gram of D-. So, they titrate the amount
20 they use.

21 This is very similar to cigarettes. When
22 we had the experiment of light cigarettes, which

1 weren't really light, people just adjusted their
2 smoking pattern.

3 They puffed harder. They covered the
4 little filter holes. So, if there's a change in
5 purity for methamphetamine, they'll just act
6 accordingly to get the dose that they need.

7 I think a difference between
8 methamphetamine and nicotine here for cigarettes,
9 is cigarettes are regulated.

10 So, people understand what the purity
11 level is of the nicotine in the cigarettes they get.

12 Whereas someone who's using
13 methamphetamine doesn't a priori, know what it is
14 that they're using.

15 And, it's this lack of consistency in
16 product purity and potency, and the frequent
17 introduction of toxic undesired impurities that
18 leads to the clinical complications we see.

19 So from a clinical and public health
20 perspective, it actually may be better to have a
21 purer and more predictable product out there.

22 Now cocaine has its own history of

1 sentencing disparities, so I don't want to repeat
2 those.

3 But it may be helpful in terms of public
4 health trends, to compare methamphetamine and
5 cocaine.

6 So for the period of 2015 to 2024, the
7 number of people who reported using methamphetamine
8 in the past year increased 50 percent. Yet cocaine
9 use has remained relatively stable during this time.

10 But during the same period of time, cocaine
11 associated deaths increased 5-fold while
12 methamphetamine associated deaths increased
13 fractionally 8-fold.

14 Again, both of those increases really
15 driven by fentanyl, rather than the pure cocaine
16 or methamphetamine themselves.

17 We should also compare not just one
18 stimulant against the other, but look at it in terms
19 of illicitly manufactured fentanyl.

20 As mentioned previously, methamphetamine
21 related deaths involving, tend to involve fentanyl.

22 And 43 percent of the 75,000 fentanyl

1 overdose deaths in the United States, involved
2 methamphetamine.

3 Emergency departments also see 84,000
4 non-fatal overdoses annually, and fentanyl specific
5 hospitalizations while those aren't measured, we
6 know there are about 900,000 opioid related
7 hospitalizations each year.

8 Which is four times the number of
9 hospitalizations caused by methamphetamine.

10 And since the number of people using
11 fentanyl is about a quarter of the number of people
12 who use methamphetamine, there's an incredible
13 disproportion in terms of the public health impact
14 of fentanyl versus methamphetamine.

15 And unlike fentanyl where we have very
16 effective medications to treat, we really don't have
17 any medications right now for methamphetamine.

18 And the treatments that we do have are
19 labor intensive and last only a few weeks to months,
20 and have sub-optimal outcomes with 60 percent of
21 people being treated for methamphetamine use,
22 returning to methamphetamine within the year

1 following treatment.

2 And people who have both methamphetamine
3 and an opioid use disorder are less likely to get
4 the effective treatment for their opioid use
5 disorder, which places them at increased risk for
6 poor outcome and death.

7 So we definitely need ongoing investment
8 in medication development, and innovations and
9 behavioral treatment for methamphetamine.

10 But I want to circle back to the question
11 of whether there's a pharmacological medical or
12 public health rationale for methamphetamine
13 sentencing guidelines to be based only on purity.

14 The answer is, no. But if purity is taken
15 into consideration, it should also apply to other
16 drugs.

17 Here the real question is, should higher
18 purity be upward adjusting or downward adjusting,
19 to sentencing recommendations?

20 It is fentanyl's unpredictable
21 variability in purity, with the additives of
22 xylazine, medetomidine, illicitly manufactured

1 benzodiazepines like we saw last month in Baltimore
2 that enhance the sedation and contribute to
3 fentanyl's harms.

4 In this case, increased purity may
5 actually have a public health benefit, because it
6 gets rid of these toxic contaminants.

7 Driving down the purity of
8 methamphetamine, we don't know if it will have a
9 similar negative consequence in terms of the
10 introduction of potentially toxic and dangerous
11 additives like xylazine, or other like we've seen
12 with cocaine, levamisole, which can impact the
13 immune system.

14 So I think ultimately, the complications
15 related to drugs area a combination of their direct
16 medical effects, and how our society chooses to
17 respond to people who use drugs.

18 So, I think the choice of this committee
19 most directly relates to the latter, but the public
20 health implications of the choices that this
21 committee makes, shouldn't be underestimated.

22 And I'll conclude with that, so thank you

1 very much.

2 CHAIR REEVES: Thank you, Dr. Bart.

3 DR. JONES: Thank you very much, and
4 appreciate being on the panel with esteemed
5 colleagues. I think we've all cited each other's
6 research.

7 And Dr. Bart basically covered most of what
8 you have in my written, so I won't go through all
9 of that.

10 I think I'll just sort of reflect on the
11 epidemiology of methamphetamine use, and reinforce
12 some of the ideas that have already been shared.

13 And, this has been an area of research for
14 me over the last several years, really trying to
15 understand the re-emergence of methamphetamine in
16 the context of the opioid crisis.

17 And, where was a relationship or where was
18 there not a relationship.

19 And the research we've done with the
20 national data from the National Survey on Drug Use
21 and Health, we saw that methamphetamine use
22 increased over the last decade.

1 The most recent NSDUH data have some
2 challenges with looking back over longer periods
3 of time, but we still see that that has generally
4 been an increase over time.

5 But I think the takeaway point is that not
6 only was the use increasing, but the frequency of
7 use, sort of the severity of use.

8 So, more frequent daily use, people
9 injecting, greater proportion with methamphetamine
10 use disorder.

11 So sort of the intensity and frequency,
12 and the risk for harm had been shifting.

13 We also saw that use was happening across
14 a broader population of people. If you look at sort
15 of the early to mid-2000s, you tended to see certain
16 pockets of the country that had methamphetamine use,
17 but other areas really didn't.

18 And, we've seen increases really across
19 most demographic groups, in the community-based
20 survey data on drug use.

21 And so, that is I think important as we
22 think about the public health implications. For

1 instance, non-Hispanic Black populations
2 historically had really low rates of
3 methamphetamine use, and much higher rates of
4 cocaine use.

5 While the cocaine use rates still remain
6 high, we've seen an increase in methamphetamine use.

7 And even in the populations where
8 methamphetamine use has been high historically,
9 those populations still have high rates.

10 So, people in rural areas, tribal
11 populations, people living in the West. It's
12 pretty consistent in the research that we've done.

13 The last panel brought up the issue of
14 polysubstance use. Again, whether it's treatment
15 data, community-based data, we see that with people
16 who use methamphetamine, that there's high
17 prevalence of co-use of alcohol, nicotine, other
18 illicit substances, prescription, opioid misuse,
19 prescription stimulant misuse.

20 And, based on the NSDUH data, it seems that
21 people who are using methamphetamine, are sort of
22 on the far end of the spectrum. They have used lots

1 of different substances.

2 And, we have far more people who are
3 meeting criteria for use disorder than say,
4 initiating methamphetamine use in the past year,
5 which is different than we see for some of the more
6 commonly used substances.

7 We also looked at treatment data, and we
8 found very similar trends. Demographic groups that
9 historically had low rates of methamphetamine use
10 at treatment admission saw increases.

11 We saw that the increases were largely
12 connected to continued increases in co-use of
13 opioids.

14 Whether it was people who were using
15 opioids as their primary substance coming into
16 treatment, we saw methamphetamine rising among that
17 population, and vice-versa.

18 People who said methamphetamine was their
19 primary substance increasingly were reporting use
20 of opioids.

21 And this really tracks closely with the
22 supply data from DEA where you see the West has

1 historically had much more methamphetamine, but the
2 Northeast actually had some of the largest increases
3 in treatment admissions for methamphetamine.

4 And that's consistent with an increase in
5 supply in those communities.

6 The other thing that we saw in the
7 treatment data that is reflected in the
8 community-based data, is a shift away from smoking
9 and an increase in injecting.

10 We saw that whether somebody also reported
11 opioid use, or not. It was sort of an across the
12 board shift.

13 Smoking was still the most common route,
14 but it had been going down over time whereas
15 injection was going up.

16 Again, consistent with the idea that
17 people are engaging in more riskier behaviors with
18 methamphetamine use.

19 And then as was just mentioned on the
20 mortality data, again, about two-thirds of overdose
21 deaths that involve methamphetamine or per CDC
22 classifications psychostimulants with abuse

1 potential, which is primarily methamphetamine,
2 two-thirds of those deaths involved opioids, as
3 well.

4 What we've seen in the last year as
5 overdose deaths have gone down, the rate of decline
6 for substances like fentanyl or synthetic opioids,
7 has been going down faster than deaths involving
8 psychostimulants.

9 So as a proportion of deaths,
10 psychostimulants with abuse potential or
11 methamphetamine, has actually been going up as a
12 proportion of overdose deaths.

13 So, something to keep an eye on to see as
14 we start to look at demographic sub-groups or
15 geographic areas, what might be driving some of
16 that, and how might the supply be contributing.

17 And then the last area again, I just want
18 to reinforce on the treatment side is that we really
19 have challenges in the treatment space.

20 We have many people who could benefit from
21 treatment, but those treatments are difficult to
22 operationalize in many medical settings.

1 Contingency management is probably the
2 best study, but it has its own operational
3 challenges.

4 Although the most recent ASAM, American
5 Academy of Addiction Psychiatry guidelines for
6 stimulant use disorders does talk about
7 pharmacological treatments, those are currently
8 off-label.

9 And so, there is a need for continued
10 investment from both NIH and FDA, to bring products
11 to market with FDA approval for treatment of
12 stimulant use disorder.

13 So, we have psycho social treatments. We
14 have off-label use. But it is really not meeting
15 the need of populations, just given the sort of broad
16 spectrum of impact of methamphetamine use disorder
17 in the country.

18 So with that, you've got all the nerdy
19 statistics. I won't go through all of those but
20 happy to answer any questions.

21 Thank you.

22 CHAIR REEVES: Thank you, Rear Admiral

1 Jones.

2 Turn to my colleagues. Any questions for
3 this esteemed panel?

4 Yes, starting Commissioner Meisler.

5 COMMISSIONER MEISLER: Thanks for being
6 here. This question is primarily for Dr. Shoptaw
7 but any perspectives are certainly welcome.

8 I took your testimony to focus on the
9 dangers associated with frequency are basically to
10 say that the worse health outcomes are associated
11 with frequency more so than purity.

12 But I guess I'm wondering whether those,
13 these two things are related. So, just to my kind
14 of primitive understanding, I could imagine a
15 situation of which higher purity, higher potency,
16 might lead to higher addictive potential.

17 And if someone is then inclined to use the
18 drug more often because they want the high more
19 often. And, purity in that sense fuels more
20 frequent use.

21 Is that a way to think about or am I missing
22 something there?

1 DR. SHOPTAW: So that's a great question
2 and I've thought about that, and I think the horse
3 is already out of the barn.

4 From the presentations this morning, you
5 have to search to find lower purity and lower quality
6 methamphetamine.

7 And, people don't have a market where they
8 can search so they're getting high dose
9 methamphetamine.

10 So as I was preparing this report, it sort
11 of, that was a challenging thought in my mind was,
12 how do you separate out the issue of purity and the
13 issue of frequency?

14 And, the bottom line answer to that is you
15 can't because right now everything is so pure that
16 you're talking about a hypothetical. It's not
17 going to happen.

18 So, in terms of thinking about sentencing
19 guidelines, it's not a relevant question.

20 CHAIR REEVES: VC Mate?

21 VICE CHAIR MATE: Thank you all so much
22 for joining us today. And for your written

1 testimony, we appreciate it.

2 I had a question, I think this maybe for
3 everyone but I think Admiral Jones, you brought this
4 up in terms of looking at the mortality data.

5 And, I've seen references to the CDC's
6 overdose deaths and involving methamphetamine, or
7 involving fentanyl.

8 And when we're looking at those numbers,
9 with each of those, is it possible that there are
10 other substances involved and that's one of them?

11 I'm just curious about how to understand
12 that data and --

13 DR. JONES: Sure.

14 Yes, and it is something that is commonly
15 misrepresented in the media, and misunderstood.

16 So, when a person dies from an overdose
17 and a medical examiner or a coroner, or somebody
18 who is certifying the death fills out the death
19 certificate, essentially an individual can have one
20 underlying cause of death.

21 So that in this case, would be drug
22 overdose. But they can list up to 19 other

1 contributing causes.

2 And, that might be multiple substances,
3 or other circumstances that contributed to the
4 death. But were not necessarily the underlying
5 cause.

6 So, when CDC first, when I was at CDC 15
7 years ago when we first started reporting on
8 overdose deaths, we would label things like opioid
9 deaths, cocaine deaths.

10 But what we found is that people would then
11 try to add those up. And there was a lot of overlap.

12 It really is more common to have multiple
13 substances in an overdose death, than a single
14 substance.

15 So we started using the term opioid
16 involved, or opioid related, just to reflect that
17 yes, the opioid, somebody made a, a medical examiner
18 or a coroner made a determination that the opioid
19 contributed to the death.

20 Not simply that it was present, but that
21 it contributed to the death, but there were other
22 substances that could be involved.

1 CDC has a newer data system called the
2 State Unintentional Drug Overdose Reporting System,
3 which allows for a bit more granularity in the
4 particular drugs and drug combinations involved in
5 overdose deaths.

6 And in their most recent dashboard, they
7 report about 21 percent of the overdose deaths from
8 about 40 or so states, involved fentanyl only.

9 So, that means in most cases even with
10 deaths that involved fentanyl, other substances,
11 80 percent of the time, other substances are
12 involved. And, a lot of time it's opioids and
13 stimulants that are involved.

14 So it's just a more nuanced way to talk
15 about the data. You wouldn't add up deaths that
16 involved methamphetamine and deaths that involved
17 opioids, because you would get more than the total
18 because there is overlap.

19 VICE CHAIR MATE: That was very helpful,
20 thank you.

21 DR. JONES: Sure.

22 CHAIR REEVES: Vice Chair Restrepo.

1 VICE CHAIR RESTREPO: Is there anything
2 unique, and this is for anybody on the panel.

3 Is there anything unique about
4 methamphetamine as opposed to other drugs, that you
5 think judges, probation officers and folks in the
6 system should be aware of?

7 DR. SHOPTAW: I've thought about that as
8 well. So, methamphetamine is not like a, it's not
9 a prototypical drug.

10 It doesn't fit well with other drugs when
11 you think about opioid use, or when you think about
12 cocaine use, when you think about other drugs. It's
13 very different.

14 We've heard testimony today that one of
15 the problems with methamphetamine is stopping using
16 methamphetamine. It's very hard.

17 And the reason for that is because when
18 you stop methamphetamine use, you have this very
19 awful negative withdrawal thing that happens.

20 It's not as severe as an opioid use
21 disorder so it doesn't drive you immediately back,
22 but what happens is it's sort of like having a bad

1 month.

2 And so, all it takes is one dose of
3 methamphetamine to take away all of that ick. And
4 so, then automatically you're back and running.

5 So, and you're feeling better. That's
6 called negative reinforcement, and that's the
7 hardest behavior to extinguish that there is.

8 So, one of the things that I kind of take
9 hope from when I'm thinking about methamphetamine
10 and what we should be thinking about, is finding
11 way so reinforce using less frequently.

12 And so, the idea in our data, in our cohort
13 data, we see that people don't go from no use, to
14 daily use.

15 That the transitions that people have in
16 their methamphetamine use patterns and it's very
17 reliable, happen about a year at a time.

18 And, they go from daily to like weekend
19 warrior or back. Or from weekend warrior to not,
20 and maybe back.

21 But they don't go from not at all to daily.
22 Or daily to not at all. That's a very infrequent

1 behavior pattern in our 500 men we've been following
2 every six months, for 11 years.

3 So I think that's an important point is
4 just to remind people that this is really tough.

5 It's really hard to get, we need to widen our
6 perspectives in thinking about what we need to do.

7 That this isn't something you can just go
8 to a methadone clinic or take some buprenorphine,
9 and you're going to be able to be a tax payer.
10 That's not the way this works.

11 And so having that sort of understanding
12 that that is the task in front of the person in front
13 of you, might be helpful.

14 DR. JONES: Yes, the only things I would
15 add just based on some of our work again, the
16 prevalence of co-use.

17 It's not specific to and just say
18 methamphetamine as a chemical, but people who are
19 using methamphetamine, it's a prevalence of co-use
20 of other substances or co-occurring use disorders.

21 But also prevalence of mental illness, or
22 mental health challenges among people who are using

1 methamphetamine.

2 So as Steve said, it's complicated in their
3 environment, right? Violence, other, other
4 behaviors that are playing out. And the mental
5 illness side of that can further complicate
6 treatment.

7 And sometimes it may be that there are
8 acute mental health challenges as a result of
9 chronic methamphetamine use, and then sometimes
10 there are underlying mental health challenges.

11 So from a treatment perspective and a
12 recovery perspective, those just add to complexity
13 that yes, that exists for some other substances but
14 maybe not to the same degree.

15 The other piece is that as a proportion
16 of people who are using, at least based on the NSDUH
17 data, there's much larger proportion of people who
18 use methamphetamine that have a use disorder.

19 Or meet criteria for a use disorder
20 compared to alcohol, cocaine, marijuana, other
21 prescription opioids, or prescription stimulants
22 that are misused. Or even heroin.

1 We tend to see that methamphetamine again
2 as a proportion of people, tend to be more on the
3 severe spectrum.

4 And I think that's as all the reasons of
5 sort of strong addictive potential, reinforcing
6 effects, the negative reinforcement, all of those
7 things I think contribute to that.

8 DR. BART: I think I completely agree with
9 Rear Admiral Jones. Keeping in mind multiple
10 substance being used.

11 And, there are many datasets that will show
12 people who use multiple substances especially
13 methamphetamine and opioids, just have more levels
14 of medical complications, mental health
15 complications, than people who only use either drug.

16 Also, we haven't really talked about it
17 so much, and I don't want to feed into the stigma
18 of people who use methamphetamine are zombies and
19 they're gone, and we should write them off.

20 But there are some initial cognitive
21 issues in people who are especially coming off of
22 just using methamphetamine.

1 And, I think when it comes to judges or
2 others who are maybe in a position to sentence people
3 to treatment, or have that drug court procedures,
4 et cetera.

5 Asking people to jump through many hoops
6 sometimes sitting through three hours of treatment
7 a day, when cognitively they aren't quite ready to
8 have the attention span to jump through all those
9 hoops and sit through three hours, is maybe not the
10 best utilization of resources.

11 And tailoring the interventions to people
12 who are using methamphetamine, rather than a generic
13 sort of one-treatment, one-size-fits-all, may be
14 something to consider within the courts, or for
15 those judges who may be sentencing people to
16 treatment.

17 What is the nature and the quality of that
18 treatment they are being sentenced to?

19 CHAIR REEVES: Dr. Bart, I have a couple
20 of follow ups with you because I think you opened
21 up your testimony, I think, talking about a two year
22 decrease in life expectancy for every year that is

1 served in prison.

2 Do you find yourself, persons who have
3 returned to the community, are they turning to you
4 or others for addiction treatments even after having
5 been incarcerated?

6 Do you see what I'm asking?

7 DR. BART: Yes, absolutely. In fact,
8 there's an increase awareness to create some form
9 of what's often referred to as transitional care.

10 So, transitional medical care, that
11 transition from incarceration into the community.

12 Because there's such a huge fall off of
13 care. Again, you've lost all your benefits because
14 now you're incarcerated, so how are you going to
15 get your Medicare, Medicaid, or insurance?

16 All the gaps of the impact of having a
17 criminal record now. It's harder to get a job,
18 harder to get housing.

19 All of these downstream consequences that
20 are also negatively impactful on health, people are
21 struggling with makes getting health care maybe
22 lower down on the list of priorities.

1 So creating better transitions, these
2 transitional clinics for people to get care to help
3 drive down maybe some of the negative health
4 consequences that occur during that period of
5 incarceration where people's not just addiction and
6 mental health may not be optimally managed.

7 But again, other medical diseases that
8 aren't being diagnosed because we have inadequately
9 funded health care within the criminal justice
10 system.

11 Diseases that aren't optimally being
12 managed because of cost savings measures within the
13 criminal justice system.

14 So, there's an incredible opportunity to
15 at least pick up on those at times of release to
16 begin treating these disorders, including picking
17 up the addiction treatment to help drive down that
18 return to drug use.

19 I remember speaking to one person coming
20 out of prison and he had done this many times, in
21 and out of prison.

22 And for him, he would say the drive home,

1 I lost it because I'm not used to seeing the world
2 go by 50 miles an hour.

3 That was enough to set him off. And we
4 don't have systems in place to really help during
5 that difficult transition.

6 So again, trying to find a job, trying to
7 find housing. Dealing with this overwhelming sense
8 after being institutionalized, makes it really easy
9 to go back to drug use.

10 And so, the better we can set up these
11 transitional systems, or preferably even avoid
12 getting people incarcerated in the first place, at
13 least we can do things to prevent that return to
14 drug use and increased risk that comes with it, of
15 loss of tolerance and maybe now medical
16 complications because they returned to use after
17 that period of incarceration.

18 CHAIR REEVES: Any further questions from
19 this panel?

20 (No audible response.)

21 CHAIR REEVES: Thank you, gentlemen, so
22 much. We appreciate you.

1 The final panel for today will provide us
2 with treatment provider perspectives on this issue.

3 First, we have Dr. Edwin Chapman, a specialist for
4 over 40 years in internal medicine and addiction
5 medicine in the District of Columbia.

6 Second, we have Amanda Jernigan, who
7 serves as Corporate Outpatient Director at
8 Gaudenzia Addiction Treatment and Recovery
9 Services. Dr. Chapman, sir, we're ready when you
10 are.

11 DR. CHAPMAN: Thank you, and thank you for
12 having me. I just want to preface this
13 conversation. My office is actually about two
14 miles from here in Northeast D.C. and I've actually
15 practiced for 50 years. I'm a 1973 graduate of
16 Howard University.

17 So, we've really thoroughly covered the,
18 what I call the tail of the elephant, the supply
19 side and punishment, but if we're really going to
20 look at the whole elephant, we need to look at the
21 head and the body.

22 So, when we look at treatment, and before

1 I get into treatment, I'd like to mention several
2 common denominators that we've noticed related to
3 demand. According to a Commonwealth Fund study,
4 the United States leads the world in overdose
5 deaths.

6 Our overdose death rate is 324 per million
7 as of 2022, as opposed to France and Portugal, that
8 are nine and seven respectively. So, we really have
9 to look underneath the cover as to why is there such
10 a demand for illicit drugs in our country?

11 Two Princeton economists, Nobel Prize
12 winners, Anne Case and Angus Deaton, published a
13 study around 2013, 2015, showing that with the
14 closure of automobile assembly plants, within five
15 years, there's a dramatic increase in overdose
16 deaths and alcohol use.

17 So, we can see that there's clearly an
18 economic component to what we're seeing, and that
19 brings in the stress factors. So, when we look at
20 any other substance abuse/use, we also have to look
21 at our healthcare system.

22 The Commonwealth Fund again did a study

1 that was just recently reported that the United
2 States ranked tenth out of ten industrialized
3 countries in terms of access to care, although we
4 have the highest-cost system in the world.

5 So, when we look at all of these factors,
6 we really have to really look at this in the context
7 of treatment access. My experience here in
8 Washington, D.C. is right now, I treat primarily
9 opioid use disorder.

10 One hundred percent of my patients are
11 opioid use disorder patients, and I've been treating
12 opioid use disorder since the year 2000, first in
13 a methadone clinic, but then in my private practice
14 from 2005 to the present.

15 In 2014, we first noticed an increase in
16 the fentanyl supply. So, we had, we only had 83
17 or 84 overdose deaths in the District in 2014. By
18 2015, we saw 20-percent fentanyl, and by 2019, we
19 had 91-percent fentanyl. Today, we have 96-percent
20 fentanyl.

21 Most of our associated drugs are, alcohol
22 would be probably number one, cocaine, and then

1 increasingly, over the past several years,
2 amphetamine. We did see a marked uptick with
3 Xylazine in the past two years, but most recently,
4 we've seen more amphetamines in our drug supply,
5 which is relatively unusual for Washington, D.C.

6
7 My patient population is 98-percent
8 African American and primarily on the east side of
9 the city. So, those are the factors from a
10 demographic standpoint that really account for our
11 population.

12 In 2023, we had the highest overdose number
13 of deaths, which was 522. Only nine patients, only
14 nine patients had buprenorphine in their system,
15 and only 24 patients had methadone in their system,
16 so access to treatment is clearly a factor.

17 What we've noticed recently, because we
18 do have polydrug users who are testing for multiple
19 drugs, that when we are able to successfully treat
20 the opioid use disorder, in many instances, the
21 associated drugs, like amphetamines and cocaine,
22 also disappear. Methadone and buprenorphine do not

1 treat those drugs directly.

2 So, we know that most of the time, our
3 patients are getting these drugs not knowing that
4 they're mixed in the drug supply, so it's really
5 the fact that we have this polydrug supply in the
6 District of Columbia that's accounting for these
7 other drugs. Once the opioids disappear, we very
8 rarely see amphetamines by themselves associated
9 with that. I'm going to stop there.

10 CHAIR REEVES: Okay, thank you. Ms.
11 Jernigan?

12 MS. JERNIGAN: Hi, thank you very much for
13 this opportunity to speak to you all today. I'm
14 a licensed clinical social worker and I'm the
15 Director of Clinical Services at Gaudenzia. We are
16 the largest nonprofit provider of treatment, both
17 for mental health disorders and substance use
18 disorders, and we've been doing this for 56 years,
19 not me personally, just for the record, I've only
20 been doing it for 23. I just felt like I needed
21 to say that.

22 But, you know, we have seen a big change

1 in the drug front, and it continues to change. Even
2 saying I've been doing this for 23 years hurts a
3 little bit to say out loud, but the drug trends
4 change over time.

5 And, you know, I'm here to share what we're
6 seeing on the ground level when it comes to
7 methamphetamine use involving nature of the drug
8 supply and how that impacts our treatment, and
9 behavior of the client, and the outcomes for the
10 individuals that we serve.

11 Gaudenzia is a nonprofit and we actually
12 serve the people kind of nobody else wants to serve.

13 They are oftentimes under-insured, have no
14 insurance, are homeless, have been in the criminal
15 justice system for many years. We work with the
16 Department of Corrections, those types of
17 individuals.

18 And as we know, methamphetamine is a
19 powerful central nervous system stimulant. We're
20 seeing it being injected, we're seeing it being
21 smoked, we're seeing it being snorted, and we're
22 seeing it being taken orally

1 And for the prolonged use, many of these
2 individuals develop dependence, and in the
3 substance abuse world, those are the harder people
4 to treat. We have abuse and we have dependence.

5 And while it's derived from
6 methamphetamine, which was widely prescribed in the
7 '50s and '60s, today's use patterns and purity
8 levels reflect a totally different landscape.

9 We're seeing it spread out regionally, and
10 because Gaudenzia is spread out regionally, we see
11 differences in different regions that we work in,
12 but it's estimated that nearly five million
13 Americans have used methamphetamine at some point,
14 whether that was intentional or unintentional, but
15 the short-term and long-term effects can be severe,
16 ranging from stroke, cardiac arrhythmia, and
17 intense anxiety, to paranoia, hallucinations, and
18 structural changes in the brain.

19 In treatment, we have to address these
20 symptoms directly, while also helping individuals
21 stabilize, build resilience, and access
22 evidence-based treatment interventions at every

1 level of care.

2 So, we're always paying close attention
3 to what's happening in the current drug supply.
4 We have a lot of offices in our Pennsylvania area,
5 so we follow the PA Groundhogs' reports a lot to
6 get information, and in their 2025 report, they have
7 shown a gradual decline from 84 percent in early
8 2023 to 73 percent in 2025, and this is reflective
9 of broader changes in the manufacturing and
10 distribution of the drug, but also impacts us
11 clinically.

12 When the purity drops, individuals may
13 increase their dosages to achieve the same effect,
14 raising their risk of toxicity or what's called
15 overamping, an unintentional mixing of other
16 substances, which can be life threatening.

17 We also work closely with law enforcement
18 agencies in Pennsylvania, and Maryland, and
19 Delaware, and we've seen, in 2024, there was over
20 3,500 arrests related to amphetamine and
21 methamphetamines, but in the first half of 2025,
22 we're already at 1,500 arrests, and that's just

1 going to continue to grow.

2 We're seeing shifts as well in the
3 treatment of individuals coming into treatment.
4 So, we run a frontline report every year, and our
5 data showed a three-percent agency-wide primary
6 diagnosis of methamphetamine use disorder. This
7 has been consistently climbing over the last few
8 years, and this varies across states.

9 So, we saw a one-percent increase of
10 methamphetamine primary use disorder for Maryland,
11 eight percent in Delaware, and of interest in
12 Delaware, that is a women-only program, so all of
13 that came from women that are using
14 methamphetamines, so it's not just men, and three
15 percent in Pennsylvania.

16 The actual only decrease that we saw was
17 in our Washington, D.C. program, where we saw a
18 three-percent decline in the methamphetamine
19 primary use, but these numbers do not even indicate
20 the number of individuals who use methamphetamine
21 as a secondary or tertiary diagnosis.

22 We're also seeing trends increase, and

1 this underscores the regional variation in supply,
2 availability, and user behavior. This is also
3 affected oftentimes by seizures, raids, all of those
4 types of things that affect in the influx of the
5 drug in the market.

6 Detoxification and withdrawal management
7 are often necessary for individuals with long-term
8 methamphetamine use, and during which time, we're
9 addressing both those physical and those
10 psychological symptoms.

11 There are both long-term and short-term
12 physical effects of methamphetamine, which include
13 stroke, cardiac arrhythmia, stomach cramps,
14 shaking, and mental health symptoms such as anxiety,
15 paranoia, hallucinations, and those changes to the
16 brain.

17 Withdrawal can cause intense cravings,
18 fatigue, depression, and severe body aches. And
19 for clients that are experiencing meth-induced
20 psychosis or suicidal ideation, medical supervision
21 is critical.

22 I know we talked a lot about medications

1 today, but there are a lot of off-label medications
2 currently used to treat the cravings, which is the
3 big piece of the methamphetamine use, such as
4 Topamax and Wellbutrin, but we don't have the
5 medical-assisted treatment that we do when we talk
6 about opioid use disorder.

7 So, we're doing the best we can, but we're
8 waiting for those things. I heard 12 to 24 months.

9 I'm just holding you to that. No pressure from
10 my perspective.

11 But there is some early research going
12 through the National Institutes of Health. A
13 combination of medications of naltrexone and
14 Wellbutrin together is showing promising effects.

15 And once they're stabilized, clients
16 benefit from behavioral therapies, and those
17 evidence-based approaches include contingency
18 management, cognitive behavioral therapy,
19 motivational interviewing, and using
20 evidence-based curriculums, such as the Matrix
21 Model by SAMHSA. These therapies and curriculums
22 help the individuals build coping skills, prevent

1 relapse, and strengthen motivation to stay engaged
2 in treatment.

3 And once you've finished higher-intensity
4 treatment, it's always recommended for somebody
5 with methamphetamine use disorder to transition to
6 lower-intensity programs where they continue their
7 therapy while slowly reintegrating into the
8 community.

9 Support during this stage includes things
10 like getting them connected to peer recovery support
11 groups like Smart Recovery, Narcotics Anonymous,
12 Celebrate Recovery, or Refuge Recovery, and clients
13 also begin connecting with outpatient care,
14 workforce development, primary care, mental health
15 providers, and other prosocial supports.

16 Treatment methamphetamine disorder is
17 complex, but it is treatable. As research evolves
18 and new tools become available, we remain committed
19 to adapting our practices and staying grounded in
20 what works. Thank you for this opportunity to
21 share.

22 CHAIR REEVES: Thank you. I'll turn to

1 my colleagues. Any questions?

2 VICE CHAIR RESTREPO: Same question I
3 asked the previous panel about what, if anything,
4 is unique about methamphetamine that you would want
5 judges, probation officers, and other folks in the
6 criminal justice system to take into consideration?

7 MS. JERNIGAN: I think it's important that
8 we quantify what treatment looks like from the
9 criminal justice perspective, because I've seen it
10 in various ways of, like, just go for the evaluation,
11 and you check the box, and that's treatment, or go
12 to one level of treatment, but don't go to the other
13 levels of treatment, and that's not what the
14 research is seeing is indicative for
15 methamphetamine use disorder.

16 So, treatment could look like a
17 high-intensity detox, to a high-intensity
18 residential program, to a low-intensity
19 residential, to outpatient services, but we don't
20 always get the backing from probation and parole
21 to keep them in that continuum, if that makes sense,
22 so understanding that treatment is not just a one

1 and done. It's various levels, and depending on
2 the length of use, of how much they're been using
3 and the length of time they've been using, requires
4 longer exposure to treatment.

5 DR. CHAPMAN: I think if we really look
6 at just the opioid epidemic in general, only 20
7 percent of patients who actually need medications,
8 and we have three medications too that we know
9 actually reduce overdose deaths, and in the African
10 American population, it's less than ten percent have
11 access.

12 So, there are multiple factors involved,
13 economic problems, homelessness, patients being
14 separated from their families, so that all of that
15 plays into the fact that unless we're able to have
16 some kind of universal access that is free -- my
17 approach would be that anyone who needs treatment,
18 access should be free.

19 The European Model, and the reason why
20 Portugal and France have such low overdose rates,
21 is that access. They have a universal health
22 system, so anyone can get access to methadone or

1 buprenorphine.

2 What's going to happen in our system if
3 you have to work to get Medicaid? That's not only
4 going to impact the individual, it has a trickle
5 down and impacts children as well.

6 There was a study that came out two years
7 ago that showed that foster care between 2011 and
8 2021 increased. There were 321,000 children in
9 foster care because their parents had either
10 overdose or were incapacitated.

11 So, this trickle-down effect means that
12 we're impacting the next generation, and that's
13 going to be all drugs, not just methamphetamines,
14 but cocaine, alcohol. Without access, people are
15 not going to be able to get treatment.

16 CHAIR REEVES: All right, VC Murray?

17 VICE CHAIR MURRAY: I had a follow-up
18 question on the 2025 PA Groundhogs' Drug Purity
19 Report. Its results are so different than what
20 we've seen in a lot of other reports. Do you know
21 if it was focused quite a bit on pills or powder,
22 or if it was focused on crystal, or is there a

1 difference in terms of prevalence of crystal versus
2 pills in Pennsylvania?

3 MS. JERNIGAN: It did not say that in the
4 report. It just -- like everyone else said, it's
5 variable depending on the region, right? So, we
6 see different things in, like, more rural areas than
7 we do in more urban areas, and even suburban areas,
8 right? So, with Philadelphia being such a big hub
9 for, like, the drug area, I'm assuming that it's
10 probably going to be more of the powder, but I don't
11 know that for certain.

12 CHAIR REEVES: I'll just ask you one
13 question. I know Dr. Chapman has been with us most
14 of the day, so I think you've heard all of the
15 testimony. Ms. Jernigan, I know you were here for
16 at least half of the day, but is there anything you
17 want to leave us with, that you would tell us, that
18 you either heard today or that you want to leave
19 us with, with respect to what we ought to do about
20 this issue?

21 DR. CHAPMAN: I think particularly in my
22 community, where incarceration has been the

1 treatment for decades, that we need to re-educate,
2 not only the community, but also the healthcare
3 community in terms of the fact that treatments are
4 available.

5 Perhaps we don't have medications for
6 amphetamines, but certainly having housing, having
7 counseling, having support services would really
8 have a dramatic impact. And I think we can look
9 at the District of Columbia and the fact that we
10 have three medical schools here and we have a
11 homeless population that's really costing us much
12 more money.

13 Because people don't just die. They end
14 up going to the emergency room. They end up going
15 to the hospital. And when I mentioned methadone
16 and buprenorphine, I was shocked to find that
17 treatment of one patient for one year per capita
18 saves \$271,000, and I think the younger, regardless
19 of what the drug, the more likely they are to have
20 children, and then you get that downward spiral
21 because you're impacting multiple generations.
22 So, I think treatment as opposed to punitive motions

1 and incarceration is paramount.

2 CHAIR REEVES: Thank you.

3 MS. JERNIGAN: And just to kind of
4 piggyback off of that, I agree with that. I also
5 think understanding that, you know, we focus so much
6 on the opioid epidemic, that we lose sight of some
7 of these other drugs, and, like, we just need to
8 say we have a drug epidemic, and what I always say
9 to people is how are we going to address that? I'm
10 not saying -- I'm not minimizing all of the lives
11 that were lost during the opioid epidemic, but we
12 focused so much on that, we seemed to lose sight
13 of all of these other drugs.

14 In the meantime, the opioid epidemic has
15 scared a lot of the end users of the fact that it's
16 mixed with fentanyl and all of these other
17 tranquilizer-like drugs that cause all of these
18 other things, that people are switching to these
19 drugs to stay safer in a way, and I think we lose
20 sight of that, so thank you.

21 CHAIR REEVES: Thank you. I don't
22 believe there are any other questions. Ladies and

1 gentlemen who are with us in this room and those
2 who are watching the livestream, this ends our
3 discussion on these topics at this moment. The
4 Commission itself will continue this discussion.

5 I want to thank the staff again for the
6 extraordinary work that you did in collecting these
7 experts who came forward today. It was a great
8 panel. We appreciate all of the written
9 submissions as well as the verbal testimony.

10 And for those who want to keep up with what
11 the Commission is doing, www.ussc.gov. You can
12 tune into that 24/7, 365, and on Leap Year, 366.

13 Thank you so much for everything today. With this
14 now, our hearing is now adjourned.

15 (Whereupon, the above-entitled matter
16 went off the record at 2:54 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings; and that I am neither counsel for, related to, nor employed by any of the parties to this action in which this matter was taken; and further that I am not a relative nor an employee of any of the parties nor counsel employed by the parties, and I am not financially or otherwise interested in the outcome of the action.



Ahamad-Shakil Azizi

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