

Michael A. Greene
263 East 3560 South
Salt Lake City, UT 84115-4720
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The United States Sentencing Commission
One Columbus Circle, N.E., Suite 2-500
Washington, DC 20002-8002
Mr. Michael Courlander, Public Affairs Officer

Dear Mr. Courlander:

I request that this letter and the enclosed report, previously submitted to the Senate Judiciary Committee on Club Drugs, be admitted into the record on the pending Ecstasy sentencing revision. The report discusses reasons for accepting Ecstasy as a legitimate psycho-therapeutic agent and for a more sound approach when considering methods to deal with its abuse.

I neither use illegal drugs nor do I encourage the abuse of any drug, including tobacco or alcohol, because of their negative effects; but I am even more concerned for the total effect that drug prohibition has had on our society. It has diminished the public's trust in our justice system and in those governmental agencies established to protect the people. There is no reason to maintain an approach that merely continues this demoralizing trend.

The average number of deaths directly attributed to Ecstasy toxicity appears to be about ten per year (according to recent data from SAMHSA). Alcohol use accounts for 100,000 deaths per year. This is a mortality rate 10,000 times greater, yet the use of alcohol is sanctioned by the government.

It is important to ask, what is being accomplished by making criminals of those who use relatively benign drugs while sanctioning the use of much more destructive drugs. The incongruity created by such laws borders on the absurd. White is black and black is white. When a law is irrational, the enforcement of that law is unjust. I hope that any changes made to the penalties for Ecstasy use acknowledge the fallacy in increasing the severity of the consequences of a "criminal activity" whenever such increases have, for other illegal drug use, proved to be of dubious value.

I realize that these are philosophical issues and your task is to create sentencing guidelines reflecting the nature of the crime that are both rational and reasonable. I argue that it is neither rational nor reasonable to increase the criminal penalties associated with a law that is already ridiculous. The only rational and reasonable approach is to accept that people use drugs and find ways to minimize the harm that such use brings to both the individual and society. Refusing to increase the criminal penalties for the use of Ecstasy would help to minimize the harm done to both the individual and society.

Sincerely,



Michael A. Greene

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**Considerations of Michael A. Greene
Independent Researcher &
Drug Law Reform Advocate
July 21, 2000**

**Presented to the Senate Judiciary Committee
Orrin G. Hatch, Chairman
On the Event of the Utah Field Hearings
"Emerging Drug Threats and Perils to Utah's Youth"
Presented on July 6, 2000 in Salt Lake City, Utah**

Senator Hatch, thank you for the opportunity to respond to the Utah Field Hearings on the "Emerging Drug Threats and Perils to Utah's Youth" that was held in Salt Lake City on July 6, 2000. I too see a real threat to our youth from these relatively new emerging drugs. I wish to make it clear that I am firmly against the use and abuse of drugs by our youth, whether these drugs are the emerging "club drugs"- Rohypnol, GHB, Ecstasy and methamphetamine or the old standbys- alcohol and tobacco.

I applaud your efforts in fighting for our youth against these drugs, especially the insidious drug, methamphetamine. This drug's demoralizing and destructive effects on society approach even those of alcohol. Sherryl Bigelow's account of her daughter's addiction to "meth" clearly spoke of the powers of an addictive substance to destroy an individual's potential for a productive life. The illegal use of Rohypnol and GHB by individuals for their own perverted ends is unconscionable. The illegal uses that these drugs are put to as well as their hazards to the health and safety of the user deserve the most vigorous education and prevention efforts.

The issue that this report will focus on is of personal significance and of concern to many in the field of mental health. This issue concerns the use and abuse of the drug, MDMA, known as Ecstasy. The DEA Drug Intelligence Brief states that MDMA, "produces profoundly positive feelings, empathy for others, elimination of anxiety, and extreme relaxation-hence the name, 'hug drug'."¹ It is easy to understand the allure of a drug with effects such as these. Though the effects of the drug seem benign enough, the potential hazards of unsupervised use in uncontrolled environments are very real and must be considered when evaluating the illegal use of this drug.

Current status of MDMA

MDMA was placed in Schedule I of the Controlled Substances Act in 1986.² This decision was made against the recommendation of the DEA Administrative Law Judge, Francis L. Young. He recommended MDMA be placed in Schedule III to allow continued medical research and treatment. The ultimate placement of MDMA in Schedule I was primarily based on its abuse potential. The aspect of MDMA's "currently accepted medical use" was, and perhaps soon will be successfully, challenged. The DEA Drug Intelligence Brief on MDMA lists the most serious complications of unsupervised

use as, "severe dehydration and, in some cases, death from heat stroke or heart failure."¹ The data available from medical examiner reports compiled by the Substance Abuse and Mental Health Services Administration (SAMHSA) report zero deaths from Ecstasy for 1997. These results are surprising when considering that tens of thousands of users are taking this drug every weekend across the country in uncontrolled conditions using indeterminate dosages. With a relatively safe-use record such as this, we must reevaluate the judiciousness of placing MDMA in the same risk category as GHB, Rohypnol, methamphetamine and other Schedule I drugs.

MDMA in Psychotherapy

This report will focus on the potential psychotherapeutic use of MDMA. A video included in the testimony of DEA Administrator, Donnie Marshall as well as the DEA's Brief describes MDMA, "as a therapeutic agent [used] by small groups of therapists in the United States to facilitate psychotherapy."¹ These therapeutic uses are described in, "Subjective Reports of the Effects of MDMA in a Clinical Setting."³ The officially sanctioned use of MDMA psychotherapy in Switzerland from 1988 to 1993 is reported in "Psycholytic Therapy with MDMA and LSD in Switzerland."⁴

As an honorary member of the National Foundation for Depressive Illness you must have some interest in the concerns of those suffering from depression. I have been afflicted with recurrent depression throughout my life beginning as a child. I was in my late thirties when diagnosed and I am now being treated for this condition. Though I have never used MDMA, extensive reading has led me to believe in its potential applications in mental health. Senator, I ask that you not allow the problems associated with the illegal use of MDMA to prejudice you from considering its legitimate uses. I hope that you will come to see the value of allowing research on the potential of MDMA. The remainder of this report concerns the justification for considering the therapeutic potential of MDMA.

MDMA Therapy Benefits

The accounts of psychotherapeutic use of MDMA, prior to scheduling by the FDA, consistently show significant benefit to the user's quality of life. What is most impressive in these accounts, is the measure of insight gained into the individual's

personal life and problems. The self-realizations acquired with MDMA psychotherapy are not unique to the field of psychotherapy as a whole. What is unique is that the realizations gained in a single MDMA session must usually be acquired over several years of conventional psychotherapy. Indeed, this is what proponents of this technique affirm is its fundamental advantage over conventional psychotherapy. This advantage is due to the capacity of MDMA to "promote feelings of peacefulness and acceptance that enable people to move through denial and defense in order to respond clearly to difficult realities and to experience complex emotions."⁵

Food and Drug Administration officials have granted permission to demonstrate MDMA efficacy in terminal cancer patients.⁶ "Clinical case reports suggest that MDMA can reduce acute and chronic pain experienced by end-stage cancer patients; perhaps [it is] that portion of total pain and suffering resulting from emotional, psychological, cognitive and social variables."⁵ The FDA is not requiring any further pre-clinical studies of MDMA for this study to proceed. Permission was only achieved after twelve years of regulatory appeals from the dedicated individuals at the Multidisciplinary Association for Psychedelic Studies (MAPS).⁶ This organization has been working since 1986 to establish MDMA and other agents as valuable tools for the exploration of consciousness and therapy. The willingness of the FDA to investigate MDMA is a strong indicator that there are potential benefits to its clinical use.

MDMA and Neurotoxicity

There is an on-going debate on the issue of the alleged "brain damage" (i.e. neurotoxicity) caused by MDMA. In order to show the complexity of this issue I have provided a selective bibliography of research studies on MDMA's metabolism, pharmacology, neurochemistry, clinical studies, animal and human toxicology.⁷ This partial bibliography is comprised of over three hundred studies, throughout a fifteen year period. This research still does not provide a clear answer to what appears to be a relatively simple question. Regardless of the final outcome, the effort has provided a significant gain in understanding neurochemistry.

The current debate on neural alteration by MDMA use is based on neural alteration that occurs in the rat brain when subjected to high chronic intravenous doses of

MDMA. However, it is still inconclusive whether this effect would apply to the human brain when subjects are administered low doses in a clinical setting. I argue that even if proven to occur, so called "brain damage" should not be a reason to prevent further research and medical applications.

MDMA Compared to Antidepressants

My argument is based on the well known, but conveniently over-looked, fact that all psychoactive medications alter brain chemistry, and therefore, neural functioning. How else could these drugs alter neuro-chemical processes, and ultimately behavior, without changing the way the human brain normally functions? With any drug, the potential risk must be weighed against the benefit that the use of such drug provides. This point is illustrated in Antidepressants and Receptor Function. In the chapter, How Antidepressants Work: Cautionary Conclusions, we find a statement resembling one said of MDMA, yet it addresses antidepressant effects, "In one of our studies in humans, exaggerated responses to the serotonergic effects of clomipramine persisted for as long as 34 days after we stopped clorgyline treatment; we should be concerned about the possibility that, once we have exposed a person to a drug, even for one day, there may be lasting changes in neurotransmitter systems" (pg.124). Again, from the same book, "Interrelated adaptational events in second messenger systems as well as serotonin and α_1 -adrenoceptor changes and modifications in α_2 -adrenoceptors and in dopamine, acetylcholine, histamine, GABA and other receptors have also been reported during chronic antidepressant treatment" (pg. 111).⁸

As an example of shared risk factors, compare the adverse effects of MDMA with those of a commonly prescribed antidepressant. The DEA Drug Intelligence Brief lists the effects of a MDMA overdose as, "characterized by a rapid heart beat or high blood pressure, faintness, muscle cramping, panic attacks and, in more severe cases, loss of consciousness or seizures. Other adverse effects include nausea, hallucinations, chills, sweating, tremors and blurred vision. MDMA users also report after-effects of anxiety, paranoia and depression."¹

These same adverse effects exist for the drug Wellbutrin, as listed on the patient information leaflet. A listing of Wellbutrin's adverse incidents and their frequency are included in the supporting documentation. In addition to those adverse effects matching

those of MDMA, Wellbutrin's adverse effects extend to the neurological system as: ataxia/incoordination, myoclonus, dyskinesia and dystonia, mydriasis, vertigo and dysarthria. Adverse effects for the neuropsychiatric system include: mania, hypomania, increased libido, decrease in sexual function, memory impairment, depersonalization, psychosis, dysphoria, mood instability, formal thought disorder and frigidity and occurring rarely is suicidal ideation. These adverse effects were experienced by individuals taking recommended dosages of Wellbutrin under clinical trial settings.

In addition to these more extensive risk factors, Wellbutrin exhibits some abuse and dependence producing characteristics. "In a population of individuals experienced with drugs of abuse, a single dose of 400 mg Wellbutrin produced mild amphetamine-like activity...on the morphine-benzedrine subscale of the Addiction Research Center Index...higher doses, which could not be tested because of the risk of seizure, might be modestly attractive to those who abuse stimulant drugs" also, "Rhesus monkeys have been shown to self-administer bupropion intravenously."⁹

MDMA Threat Evaluated

It is unreasonable to equate a potentially useful drug like MDMA with other "club drugs", and in particular methamphetamine, when MDMA exhibits no more danger than many drugs now prescribed. The harm in this would be in creating an unjustifiable increase in public fear and apprehension. This would only serve to further obstruct efforts to promote legitimate MDMA research without providing any real prevention of continued illegal use. MDMA deserves the opportunity of an impartial and dispassionate investigation. The FDA's Drug Abuse Advisory Committee agreed that "hallucinogens pose no greater risk than other investigational drugs."¹⁰ According to the FDA's Pilot Drug Staff medical officer, "[There are no unheard of] risks involving these compounds that we do not routinely face with every new drug we put through the Investigational New Drug process."¹⁰

It is important to distinguish between the two types of problems that can occur with the illegal, uncontrolled use of a substance, including MDMA. These two very distinct problems require very different approaches. With MDMA there are the actual physiological complications resulting from dehydration, overexertion and hyperthermia.

There are other physiological complications resulting from co-factors of MDMA use. These co-factors include: drug additives, overdoses, co-ingestion with other drugs, and ingestion of chemicals mistaken for MDMA. A rational approach for this problem would involve education, prevention and harm reduction for those who choose to use MDMA. As long as we cannot absolutely prevent illegal use of MDMA, we must do all we can to protect those who choose to use it.

The other problem involves the fears and anxieties that these very real hazards present to parents and those dedicated to protecting our youth. This problem arises in those not taking the drug and requires a full objective understanding of the actual risk to the physical health and safety of our youth. We must distinguish the health and safety factor from any moral or ideological position one may have on psychoactive drug usage.

This distinction will ensure that any official measures taken are based on alleviating the threat to the wellbeing of our youth and not on speciously alleviating the public's emotional reaction to the problem. U.S. Attorney for Utah, Paul Warner stated rightly that, "We can not prosecute our way out of this problem." Perhaps, he is implying there is need for clearly distinguishing between a real solution and one which merely duplicates past attempts at a solution. The dangers of drugs that threaten our youth do not compare to the peril of ineffectual drug policy that threatens our society.

Senator, the view of MDMA presented at the Utah Field Hearing did not give the public the full factual information they need to evaluate MDMA. Yet, your opening letter indicated that this would be the purpose of the hearing. In light of this, I request your help in fostering an attitude of recognition and acceptance of the valuable potential of MDMA in legitimate medical applications. In keeping with your pronouncement at the hearing, I would like this report and its attachments to be considered for incorporation into the official record of the hearing.

References

- 1 "Drug Intelligence Brief" MDMA-Ecstasy; Drug Enforcement Administration Intelligence Division, June 1999.
- 2 U.S. Department of Justice, Drug Enforcement Administration, "In the Matter of MDMA Scheduling," Docket No. 84-48.
- 3 "Subjective Reports of the Effects of MDMA in a Clinical Setting," Greer, G., MD and Tolbert, R., RN, MSN; Journal of Psychoactive Drugs, vol.18 (4): 319-327.
- 4 "Psycholytic Therapy with MDMA and LSD in Switzerland," Peter Gasser, MD; at the URL, <http://www.maps.org/news-letters/v05n3/05303psy.html>
- 5 "The Struggle to Conduct Research into the Therapeutic Use of MDMA," at the URL, <http://www.maps.org/research/mdma/index.html>, (pg. 3).
- 6 "June 1999: MDMA Research Permitted After Years of Effort," at the URL, <http://www.maps.org/research/mdma/0699mdma.html>
- 7 Ecstasy-Dance, Trance and Transformation, Nicholas Saunders with Rick Doblin, Quick American Archives; Oakland, CA 1996 (pgs. 241-272).
This is an excellent book packed with relevant information on all aspects of MDMA.
It may be ordered at the MAPS website at <http://www.maps.org>
- 8 Antidepressants and Receptor Function, Ciba Foundation Symposium 123, (1986).
- 9 Glaxo Wellcome, Inc., Wellbutrin (buprobion hydrochloride) Drug Insert; June 1997, RL-437, 646050.
- 10 "The Pink Sheet" 1992; 54 (29): T&G-11-T&G-12; July 20, 1992 from the Section on Trade & Government Memos.

