

March 9, 2001

Mr. Michael Courlander
United States Sentencing Commission
One Columbus Circle, N.E.
Washington, D.C. 20002-8002

Dear Mr. Courlander:

I request that I be added to the list of people presenting testimony to the Commission on March 19, 2001. My statement is attached.

Thank you.

Sincerely,


Julie Holland, MD

STATEMENT OF JULIE HOLLAND, M.D.

March 3, 2001

Judge Murphy, Ladies and Gentlemen of the Commission:

Good morning, and thank you for the opportunity to speak here this morning.

I am a psychiatrist who works in the psychiatric emergency room of Bellevue Hospital in New York City. For the past five years, I have worked nearly every Saturday night and Sunday night on what can only be called the "front line" of mental illness. I have witnessed every kind of casualty to drug and alcohol use imaginable: psychosis, severe depression, violence, suicide attempts, homelessness and self-neglect. At least three quarters of the patients I see on any given shift are exacerbating, if not causing, their psychiatric illness by using alcohol and cocaine. Less than one percent of these substance-induced psychiatric disorders are due to MDMA.

I have made it clear to my colleagues and the doctors I train that I am particularly interested in MDMA-related psychiatric cases, as I am editing a book on MDMA, and yet I have heard of only three of these cases in the past two years. Eleven percent of high school seniors in 2000 reported taking MDMA in their lifetimes; the national household survey reported that 1.4 million people between the ages of 18 and 25 have taken it as well. Given the recent popularity of MDMA, it is important and encouraging to note that the medical and psychiatric emergency rooms are not overrun with "ecstasy casualties" as one might expect. According to the Drug Abuse Warning Network data, in 1999, 19 percent of all emergency room visits which mentioned a drug or alcohol-related cause listed alcohol as the reason for the visit. Seventeen percent of drug-related visits were due to cocaine. MDMA was reported 0.3 percent of the time.

Not only are MDMA related cases a small percentage of all drug-related emergency room visits, but a large percentage of these cases are not life-threatening. The most common adverse effects from acute MDMA intoxication are anxiety or panic reactions. Also common among frequent or higher dose users is a transient depression several days after ecstasy ingestion. More serious psychiatric consequences from ecstasy use are quite rare and may represent underlying predisposition to psychiatric illness. In a recent study conducted by the physicians at the medical emergency room of Bellevue, (Rella, Int J Med Toxicol 2000; 3(5): 28) a retrospective analysis of regional hospital ecstasy cases phoned into the New York City poison control center were analyzed. There were 191 cases reported during the years 1993 to 1999 inclusive. 139 cases (73%) were mild and experienced minor or no toxicity. The most commonly reported symptoms were increased heart rate (22%), agitation (19%), and nausea and vomiting (12%). In these seven years, only one ecstasy-related death was reported, which was due to hyperthermia.

Contrast MDMA-associated morbidity and mortality with methamphetamine, for example. According to the Drug Abuse Warning Network data, in the five years between 1994 and 1998, inclusive, there were 2,601 deaths reported secondary to methamphetamine. During that same time period, only 27 deaths were attributed to MDMA. In 1999, there were 4,705 deaths recorded attributed to heroin intoxication. In 1999, 9 people died secondary to ecstasy use. Ecstasy is simply not the "killer drug" the media would like us to believe.

MDMA is less likely to cause violence than alcohol, less addictive than cocaine or tobacco, and less deadly than heroin. It is also less deadly than tobacco or alcohol, killing 400,000 and 110,000 Americans respectively each year. In 1999, heroin was the top reported drug in drug-related deaths in fourteen metropolitan areas, and ranked second in another nine. Heroin and cocaine ranked first and second when a drug was attributed directly to causing death. MDMA death statistics are so small, they do not even make the list.

As a psychiatrist, I am particularly interested in the potential therapeutic effects of MDMA. Please remember that before ecstasy became an illicit drug, it was used by psychiatrists and psychotherapists as a catalyst to enhance the efficiency and outcome of psychotherapy sessions. Thousands of people underwent MDMA-assisted psychotherapy sessions in the nineteen seventies and eighties without medical complications. I would also like to remind the commission that after the DEA's administrative law judge Francis Young heard testimony from 34 witnesses at three separate hearings, he handed down a decision in 1986 recommending that MDMA be placed in Schedule III, as he believed it did have medicinal value and less potential for abuse than drugs in Schedule I such as heroin.

Based on what I have learned over the last fifteen years, it is my belief that MDMA can be used safely when in a supervised setting. Clinical research studies utilizing MDMA have been conducted with minimal adverse effects, supporting the notion that a therapeutic dose of MDMA is not intrinsically dangerous. The context and the manner in which the drug is used contributes substantially to the risks of its use. Hyperthermia, by far the most

serious acute complication of ecstasy use, is only brought about when a person engages in vigorous activity in an overheated environment without adequately replenishing lost body fluids. In a clinically controlled setting, MDMA-induced hyperthermia has never been reported.

MDMA is a unique drug. Those experts who are most familiar with its subjective effects feel that it deserves its own drug category. It is not a hallucinogen and should not be grouped with LSD; MDMA does not cause hallucinations, there is minimal sensory or time distortion as is seen with hallucinogen intoxication. MDMA also it is not a simple stimulant to be equated with methamphetamine. MDMA has significantly less stimulant potency than methamphetamine, on the order of one tenth, also its pharmacological mechanism of action is substantially different. Patterns of chronic use and dependence seen with methamphetamine are not seen with MDMA.

I understand that initially the commission proposed that penalties for MDMA be aligned with those for heroin. MDMA should in no way be equated with heroin. First of all, there are roughly two hundred doses of heroin in a gram, as opposed to eight doses in a gram of MDMA. (A typical dose of heroin is roughly 5 mg, as compared with 125 mg of MDMA.) Secondly, there is a much higher potential for physical dependence and addiction with repeated heroin use, and there is a withdrawal syndrome which typically requires medical intervention. While tolerance to MDMA has been demonstrated, there is no withdrawal syndrome, and physically addicted laboratory animals or individuals have not been reported in the literature. There are those who use ecstasy compulsively which does reflect some psychological dependence, but these are the vast minority of users. Repeated use of MDMA results in less desired effects over time, so there is a built in limiter to chronic use. Also consider the route of administration. While heroin is typically injected, leading to potential bacterial and fungal infections as well as increasing the spread of HIV and hepatitis in those who share needles, MDMA is taken orally with no associated collateral infections. The biggest difference between heroin and MDMA is the therapeutic index, or margin of safety. Overdosing on heroin will consistently cause respiratory depression and death.

MDMA also should not be equated with cocaine, whether in powder or base form. The bulk of the patients I see in the psychiatric emergency room are either psychotic from chronic cocaine use or severely depressed and suicidal from withdrawal. These people have frequently spent every penny they have on buying more and more cocaine, and are typically unemployed and homeless as a result. Although there are clearly many people who are taking too large a dose of ecstasy too frequently, they are not simply not anywhere near the dire situation of these cocaine or heroin addicts.

It is my firm belief that people who are abusing drugs need to be educated and treated within the health care system. Behavioral change and improved self-care will not result from incarceration. Also, please consider this: unintended public health consequences from stiffer penalties will increase the likelihood of drug substitutes flooding the market, which will increase the potential risk from drugs which are more likely to cause hyperthermia and death, alone, or in combination with MDMA, such as dextromethorphan and paramethoxyamphetamine.

The penalties for MDMA possession or distribution should reflect the danger of MDMA and the potential damage to people's lives that it can cause. I see alcoholics and crack cocaine addicts every time I go to work. The psychiatric and medical emergency rooms are overrun with these casualties. I do not see people whose lives have been ruined by MDMA. I would respectfully request that the commission reconsider their proposal to increase the penalties associated with MDMA.

Thank you for your consideration in this important matter.


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