Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"An Epidemic within a Pandemic: Understanding Substance Use and Misuse in America"
April 14, 2021

Geoffrey Laredo, MPA, Principal, Santa Cruz Strategies LLC

The Honorable Frank Pallone, Jr. (D-NJ)

Chairman Pallone, thank you very much for these questions. I base my answers on my personal experience, and in this instance, am also relying heavily on language provided to me by Dr. Sandra Comer of Columbia University and the College on Problems of Drug Dependence.

1. Drug overdose deaths are at an all-time high, and a key driver of this trend is illicitly manufactured fentanyl and fentanyl-related substances. One tool for preventing the supply of fentanyl related substances is to classify these substances as under Schedule I. Mr. Laredo, could you discuss further why you believe class wide scheduling of Fentanyl analogs does not reduce harm or risk associated with substance use?

There are many examples from past years where substances were placed into schedule 1 (or were already there) and that scheduling did not result in decreased morbidity or mortality. Once our field really started focusing on the opioid overdose and addiction crisis, we succeeded somewhat in reducing the amount of opioids prescribed by doctors. Morbidity and mortality did not decrease; rates of heroin use and addiction increased. As efforts shifted to deal with heroin, fentanyl emerged and developed into the problems we see today. During the past years, several fentanyl analogs were placed in schedule one, to no effect. Then the class-wide effort was initiated, and as you know, death and disease has continued to accelerate. If I was aware of a successful class-wide scheduling effort decreasing morbidity and mortality, I would focus on it and tell you we should double down on that strategy. I am unaware of any such success.

Whether or not you choose to support class-wide scheduling, I strongly recommend you implement a MUCH more robust role for HHS in that entire process. HHS must be relied upon to determine the pharmacological activity of compounds before putting them into Schedule I. Dr. Comer's past testimony (in italics below) is illustrative of this point:

Etorphine is a very potent opioid used in veterinary medicine to tranquilize large animals and diprenorphine is an antagonist used as an antidote for etorphine. These examples illustrate how the antidote to a toxic substance and the toxic substance itself can share core chemical structures. However, the chemical structure of a compound alone cannot tell us whether it will have agonist or antagonist activity. Basic pharmacological studies must be performed in order to make this determination.

- ***Science-based agencies, specifically the FDA and the National Institute on Drug Abuse (NIDA) at the Department of Health and Human Services (HHS), should review the pharmacological activity, not just the chemical structures, of these compounds.***
- ***The role of HHS need not be as robust as the 8-factor analysis currently mandated by the Controlled Substances Act. Instead, the Committee should consider adding a role for HHS in subjecting compounds to more limited tests of pharmacological activity through animal models using a rapid process that could be undertaken by NIDA and a designated, pre-screened team of extramural scientists. In fact, NIDA, FDA, and the Drug Enforcement Administration (DEA) currently participate on the Interagency Committee for Drug Control, which reviews and prioritizes compounds that need analysis. NIDA issues grants and contracts for such analyses, as does the DEA.***

The current fentanyl crisis poses a formidable challenge to Congress and the DEA since there are literally thousands of (existing or potential) fentanyl analogues, some of which have high abuse and dependence potential. CPDD supports efforts to control the distribution, sales, and use of these synthetic fentanyls. In the face of the opioid crisis, it is tempting to globally put all compounds that are chemically similar to fentanyl in Schedule 1; however, such an action is likely to severely limit biomedical research and, in the long term, adversely impact public health. The opioid crisis is a very challenging public health issue and, arguably, we have yet to significantly turn the tide in this battle despite our current efforts. To restrict research by limiting access to potentially important compounds, based solely on chemical structure, is not likely to facilitate progress in this arena.

2. Mr. Laredo, will you discuss further how research requirements related to Schedule I substances could be streamlined and why you believe this is a meaningful policy solution?

While at NIDA, I spent several years trying to work with the DEA and FDA to agree upon and implement streamlined research requirements to enable researchers to work more efficiently with schedule 1 compounds. It was frustrating, slow work, and it is still ongoing. I am aware that the CPDD and other organizations are continuing those efforts, and I also assume that the federal agencies are part of this discussion.

In particular (again, language borrowed from Dr. Comer), these 6 suggestions could go a long way in helping the research community do more work, faster, and more efficiently. Taken together, this would be a meaningful policy solution because it allows professionals to be professional, to find answers to the problems we are facing, and to share and advance that work in an environment of scientific rigor and discovery rather than one of suspicion.

1. ***Permit researchers holding a Schedule 2 license to conduct research on all Schedule 1 drugs. Specifically, treat the process for obtaining and modifying a Schedule 1 research registration the same as is currently in place for Schedule 2 (e.g., the DEA currently does not require FDA review of Schedule 2 substances for the purpose of obtaining a license.) NOTE: 1) FDA review will still be required for clinical studies of these substances during the Investigational New Drug application process, and 2) the security requirements are the same for Schedule 1 and 2 drugs so there are no implications for diversion.***
2. ***Clarify that it is permissible for one individual to hold a Schedule 1 registration under which colleagues from the same institution may work even if those colleagues do not work directly for the registrant.***
3. ***Eliminate the requirement to store each substance in a separate cabinet and for each individual researcher to have their own storage cabinet.***
4. ***Allow registered researchers to store, administer, and otherwise work with any substances for which they hold a research registration at multiple practice sites on a single campus so long as the registrant notifies the Attorney General prior to conducting research at those sites.***
5. ***Clarify that it is permissible for researchers to make limited modifications to the substances they are researching, such as processing them into extracts, solutions, or derivatives, without having to obtain a separate manufacturing license.***
6. ***Allow individuals conducting research with a substance subsequently placed into Schedule 1 who hold a registration to conduct research with any other Schedule 1 or Schedule 2 substance to continue work on the newly scheduled substance until their new or amended registration application is approved or denied. These individuals will have to submit their new or amended registration application within 120 days of the substance being added to Schedule 1.***