

# Prioritizing Science Over Fear: An Interdisciplinary Response to Fentanyl Analogues

March 16, 2021 | Zoom

The Drug Enforcement and Policy Center hosted a virtual symposium aimed at educating advocates, congressional staff, administration officials, and scholars about the possibility that classwide scheduling of fentanyl analogues will yield unintended consequences, and to highlight evidence-based alternatives that can help reduce overdose deaths. More information about the symposium can be found at [u.osu.edu/fentanylanalogues](https://u.osu.edu/fentanylanalogues).

*Holly Griffin is the public engagement specialist for the Drug Enforcement and Policy Center and served as MC for the event.*

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## WELCOME AND OPENING REMARKS

Welcome by **Douglas A. Berman**, Drug Enforcement and Policy Center  
Opening Remarks from Congressman **Robert C. “Bobby” Scott** (pre-recorded)

### TRANSCRIPT

**Holly Griffin:** Thank you for attending today's event Prioritizing Science Over Fear: An Interdisciplinary Response to Fentanyl Analogues hosted by the Drug Enforcement and Policy Center. Before we begin, we just have a few notes we'd like to share with you. First to streamline if you're into the presentations today, we suggest that you hide non-video participants. To do that, click on the three dots at the top right corner of any participant box that has their video off and click the hide non-video participants.

Second, we want to draw your attention to... I'm sorry just going to skip ahead there for a moment. Please note that auto-generated transcription has been enabled for this event. To change how you view the automated transcription or to hide it click live transcript in the menu at the bottom of your zoom window. Finally, this event is being recorded. The recording will be made available on the event page and social media channels as soon as possible after the event. Follow us @OSULawDEPC to stay up to date on our research, programming and future events. Thank you again for joining us, and I hope you enjoy the event. Professor Berman...

**Douglas Berman:** Thank you so much Holly and welcome everybody to Prioritizing Science Over Fear. That actually could be a title for all sorts of programming, these days, but today we're talking about an interdisciplinary response to fentanyl analogues. I am Doug Berman. I am a professor at The Ohio State University Moritz College of Law. I also help run our Drug Enforcement and Policy Center.

This is a fairly new center that is the nation's only law school-based criminal justice center that focuses on the war on drugs and the intersection of drug policy, public health and criminal justice. And so, we as a center were incredibly grateful and excited to have a chance to be the host of this terrific event and particularly thankful to Grant Smith and Patricia Richman for helping to put it together and DEPC's own Jana Hrdinova and Holly Griffin for doing all the infrastructure work that makes it possible for us to be here today. My role is just to sort of set the table a bit and then get out of the way, because we have an extraordinary a group of speakers lined up and I'm very excited to hear the way they approach these issues again to prioritize science over fear, when we look at fentanyl analogues. As a little bit of a table set of course probably everybody on this Zoom knows that we're now half a century, 50 years, into the so-called modern war on drugs. Richard Nixon back in '71 talked up the importance of fighting a war in the drug policy space, and especially in the 80s, we saw that war take on a whole new problematic front when aggressive enforcement based on a severe sentencing, mandatory minimums often front and center in an effort to battle drug issues.

But now we have five decades of experience and the evidence is overwhelming: that mandatory minimum penalties don't decrease drug supply, don't decrease demand, don't decrease overdose deaths and yet still we keep fighting, despite the evidence, despite what we should have been able to learn from seeing these patterns play out throughout our criminal justice system in so many ways. We continue, it seems, to respond to drug crises with punitive responses. Policymakers are still turning to enforcement-first approaches and often without even considering, let alone integrating, the science, the evidence we've built. If we can't learn from past patterns, I don't know why we expect to do better and that's fundamentally why we're here today. We are seeking to have a conversation that connects policymakers and policy responses in the fentanyl space, particularly fentanyl analogues, where we have again signs, we have evidence and we need to build off that in order to have the right kind of response to make sure we don't repeat the mistakes of the past, yet again.

The Drug Enforcement and Policy Center is particularly honored to be able to host a group of experts from across disciplines to stress what science and evidence we have, bring that to the policy conversation, make sure we don't repeat past errors, make sure we move in the right direction. And wonderfully, we've been fortunate enough to be able to have a member of Congress speak with us to get us started. I'm extraordinarily pleased and honored to be able to introduce representative Bobby Scott. He's represented Virginia's Third Congressional District in the U.S. House of Representatives since 1993.

Anybody working in the criminal justice space knows that Representative Scott has long been a stalwart advocating for reform of our nation's broken criminal justice system, has worked successfully to pass bipartisan legislation to reduce emphasis on mandatory minimums and so he's absolutely the perfect speaker to get us started here today. So, with that again welcome again and Representative Scott take it over.

**Representative Scott:** Thank you for that introduction and thank you for hosting this webinar fentanyl analogues and drug policy. The opioid crisis has taken a devastating toll on young people and communities throughout our country. As we look to address this public health crisis, it is important to

take into account the lessons of the failed drug policies of the past. So-called tough on crime legislation fails to address the true causes of the opioid crisis will result in more incarceration of drug users and it will fail to target the laboratories outside the United States that are responsible for flooding our communities with fentanyl analogues. Since President Nixon declared the war on drugs, nearly 50 years ago, laws that ignore the evidence and research in favor of harsh penalties and more mandatory minimums has led the United States to be a leader in the world for incarceration. Mass incarceration has gotten so bad that studies have shown that it actually adds to crime, instead of reducing crime, because so many people can't find jobs because of a felony conviction. Too many parents are raising children while they're in prison and so much of the Department of Justice budget goes to waste in prisons where it could be put on for effective prevention programs that we know will actually reduce crime.

Alternatives to sentencing such as drug treatment, safe schools, community policing and gang prevention programs are much more effective at crime reduction than increased penalties. We wasted too much money on failed policies instead of investing in intervention and prevention, things we know that can address the root causes of the opioid crisis. Illicit fentanyl from the labs that produce this dangerous substance are a clear threat to public safety. We can choose to address it as a public health crisis, or we can revert back to the failed drug policies that relied on slogans and soundbites. We have three main concerns with the class wide scheduling of fentanyl analogues. First, class wide scheduling abandons evidence and expertise in exchange for expediency. We have a process that works well for designating controlled substances under the controlled substances act.

Class wide scheduling of fentanyl analogues changes a process for prosecution under the controlled substances act and allows the Department of Justice to ignore the experts at the Department of Health and Human Services and the Federal Drug Administration. Class wide scheduling would give the Drug Enforcement Agency the ability to classify any new alternative chemical version of fentanyl as a schedule I drug. This would encompass hundreds and possibly thousands of chemical compounds. Class wide scheduling also stifles research that just use some of the best weapons against the opiate the opiate crisis. Life-saving overdose treatments, such as Narcan. For example, could not have been developed under class wide scheduling because class wide scheduling creates enormous barriers for scientists studying opioid addiction by arbitrarily limiting access to an entire class of chemical compounds. Second, class wide scheduling of fentanyl analogues will add to the problem of mass incarceration. It allows for a return to the street level drug busts the late 1980s and 90s, and the bill will trigger the same mandatory minimums that have contributed to mass incarceration. Possessing an analogue substance in a quantity equivalent to the weight of one paperclip is enough to trigger a mandatory minimum sentence of at least five years. A person doesn't even have to know that the drug they're selling on the street or sharing with a friend contains an analogue substance. Class wide scheduling allows prosecutors to seek longer sentences without a mens rea requirement. Third, class wide scheduling is unnecessary.

The Department of Justice already prosecutes cases involving drug analogues under existing law. Representative Scott: The Federal Analogue Act allows prosecutors to prove that the substance is chemically similar to fentanyl and has the same psychoactive effects. The Federal Drug Analogue the

Federal law protects due process rights and is an important check on over-criminalization. We cannot, we cannot repeat the mistakes of the past and enact more laws that send more people to prison while ignoring the root causes of the current crisis, which is substance abuse. This is a public health crisis and should be treated as such. This is the approach that we should take, and we should pursue that strategy by rejecting class wide scheduling. Thank you.

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## OPENING PANEL | BACKGROUND AND OVERVIEW OF CLASSWIDE SCHEDULING

**Grant Smith and Dr. Sheila Vakharia**, Drug Policy Alliance

### TRANSCRIPT

**Holly Griffin:** Thank you Representative Scott. The next panel is Background and Overview of Classwide Scheduling. Our opening panel speakers are Grant Smith of the Drug Policy Alliance and Dr Sheila Vakharia of the Drug Policy Alliance.

**Grant Smith:** Thank you and good morning again, my name is Grant Smith. I am the Deputy Director of National Affairs for the Drug Policy Alliance and I'm pleased to be with all of you this morning. Next slide please.

50 years ago, this coming June, President Nixon declared a war on drugs. For 50 years now drug policy in the United States has been defined by fear, racism and carceral approaches. This includes the response to crack cocaine in the 1980s. In recent weeks, bipartisan legislation has again been introduced to eliminate the crack powder sentencing disparity.

Next slide please. This horrendous crack powder sentencing disparity policy was included in the Anti-Drug Abuse Act, signed by President Reagan in 1986. A set of excessive new mandatory minimums for crack and other drugs passed in reaction to a wave of sensational media headlines this took racialized fear and perpetuated mythology around crack. Next slide please. You can see some of these examples of how mythology, fear and punitive mindsets drove a punitive response to crack cocaine in the 1980s. And generated a lot of hysteria and a lot of mythology that still we're still fighting to overcome today. Lawmakers then allowed fear not science to decide policy on crack cocaine. Lawmakers then allowed get tough rhetoric and mythology to drive a punitive approach to crack rather than the health-based approach needed. And lawmakers are still cleaning up this mess today.

A mess that resulted from the mythology, the fear, and the punitive, the calls for punitive action in response to crack cocaine in the 1980s. Here is Joe Biden in 2008 when he was in the Senate describing how fear and mythology push Congress to enact the crack power disparity law.

**Recording of Joe Biden:** The current disparity in cocaine sentencing I don't think can be justified in the facts we know today and the facts we operated on at the time we set this up. In 1986 crack was the

newest drug on street and Congress was told this smokable form of cocaine was instantly addictive. And then it's a fact that a child if smoked during pregnancy was far worse than other drugs and that it would ravage our inner cities.

I remember one headline that summed it up well and it read, quote "New York City being swamped by crack, authorities say they're almost powerless to halt cocaine." And they called it the "summer of crack" in that headline. In Congress, more than a dozen bills were introduced to increase the penalties for crack because we knew so little about it, the proposals were all over the map.

**Sheila Vakharia:** So, I'm going to take over and bring us up to today. As we refer to it, commonly, the currently overdose crisis is largely driven by illicitly manufactured fentanyl and fentanyl analogues and so I'm going to talk about that in a second, but before I get there, I want to talk a little bit about what we mean by fentanyl. So, fentanyl is a synthetic opioid that was invented in 1960 by Dr. Paul J. Hanson. It was found to have tremendous benefits for pain relief. And it was 50 to 100 times more potent than morphine. It was deemed a schedule II substance, because of its medical benefit and potential for addiction. And, to this day is commonly used for a variety of surgeries and for managing some forms of chronic pain.

But in the context of our Conference today we're really talking about illicitly manufactured fentanyl and illicitly manufactured fentanyl analogues. And when we mean what we say, by illicit or illegally manufactured, we mean fentanyl and fentanyl analogues that were made in clandestine laboratories or underground laboratories, many of which are typically located outside of the United States. In order to make these these illicitly manufactured fentanyl and fentanyl analogues, a number of synthetic precursors are needed. And what we know about fentanyl analogues is that they are chemically similar to fentanyl, but they have slightly different compositions. They may actually have different psychoactive effects. And in some cases, they may not have any psychoactive effects at all. They can also have a broad range in potency and purity in terms of their effects. What we know is that although illicitly manufactured fentanyl has emerged in our drug markets, some would say around eight years ago, illicitly manufacturer fentanyl analogues have emerged in the years that have followed.

This here is a graph that illustrates the skyrocketing rates of overdose deaths in the United States over the past 20 years of our current overdose crisis. And recent estimates suggest that overdose rates only continue to increase and that there is no sign of this stopping. This diagram illustrates the involvement of opioids specifically in the overdose crisis, so you will see that there are no stimulant drugs listed. The navy-blue line is actually the line that we commonly used to identify illicitly manufactured fentanyl and fentanyl analogues and overdose deaths. And as you can see here, starting in 2013, that line dramatically increased over the subsequent years, and continues to go higher.

Meanwhile, the light blue line, which represents prescription opioids and the light green line that represents heroin show that, although those drugs were involved in growing numbers of overdose deaths that rate has slowly stabilized and, in some cases has gone down. I've drawn here a red line going up through the year 2018 to signify the year in which the class wide scheduling for fentanyl analogues was padded, implemented and passed. And as you can see the blue trajectory the dark blue

trajectory of fentanyl and fentanyl analogue involved overdose deaths continue to rise, even after that passage. Back to you Grant.

**Grant Smith:** Thank you Sheila. As fentanyl and fentanyl analogue overdoses increased, law enforcement seized upon public ignorance about these substances and growing fear about the perceived potency of these substances and circulated miss about these drugs. The media soon picked up on these myths, such as the notion that skin contact with fentanyl is lethal. Soon, a wave of media headlines fueled concern among lawmakers and calls to get tough, similar to what we saw in the crack era. Here we can see examples of fear inducing headlines, fed by law enforcement and I want to point out the last two headlines, in particular were false alarms which was often so often been the case with a lot of these media headlines that were fed by law enforcement to media.

Next slide please. Federal law enforcement agencies, like the Drug Enforcement Administration and Homeland Security further amped up the hysteria to another level around fentanyl but training fentanyl as a weapon of mass destruction, a poison that can only be stopped by tough laws and enforcement first approaches. Next slide please. Here we see Trump taking on this rhetoric, taking a hard-line stance and giving the green light to as then Attorney General Jeff Sessions to ramp up prosecutions involving fentanyl. Next slide please. In this clip from 2018, Sessions describes this belief that ramping up prosecutions involving fentanyl and fentanyl analogues will reduce supply and save lives.

**Recording of Jeff Sessions:** To prosecute every synthetic opioid case systematically and relentlessly, every fentanyl case, we can weaken these networks, we can reduce fentanyl availability, we can save lives. To system...

**Grant Smith:** Sessions delivered on this promise to ramp up a hard-line approach and response to mounting hysteria about illicit fentanyl and fentanyl analogues with the implementation in February 2018 of class wide scheduling of fentanyl analogues by the Drug Enforcement Administration.

The Drug Enforcement Administration used its temporary scheduling authority to place on schedule I all substances that are chemically similar to fentanyl. An entire class of substances, in other words, based solely on chemical structure. These substances were added to schedule one as a class under the assumption that all were at least equally or more potent than fentanyl. However, this is not the case, and regardless of potency or purity of any of these analogues, severe mandatory minimums apply, even in cases involving trace amounts of one of these analogues captured under class wide scheduling.

**Sheila Vakharia:** So yeah, so here we have an illustration of the continuum of potency. So, on the right hand we can imagine highly, highly potent fentanyl analogues and on the left-hand side, we can imagine the continuum going forth with less potent analogues. And in the middle in the yellow I have illustrated fentanyl.

So, as you can see here the umbrella of fentanyl analogue class wide scheduling would capture all analogues in the color of orange, for instance, and that includes ones that we know, have known increased potency, for instance ocfentanyl and others, and it also includes you know fentanyl analogues

to the left-hand side that may actually have reduced potency such as acrylfentanyl, which is only has 75% of the potency of fentanyl, for instance. And it includes ones that do not yet exist or have not yet been identified in our drug markets symbolized by some of these dots here that just have question marks, you know analogues that we still do not know exist that may or may not be more or less potent than fentanyl, but it also includes the analogues that I have hovering here that aren't connected to the continuum at all, analogues that may not, may not have any psychoactive effects at all.

So, class wide scheduling encompasses a broad range of analogues with the assumption that they are all equally or greater in potency but actually they may actually be lesser in potency or not have any sort of psychoactive effect at all.

**Grant Smith:** As we said, the Drug Enforcement Administration uses its temporary scheduling authority to implement class wide scheduling. This was set to expire in February of 2020 last year. Faced with this expiration, Trump's Department of Justice and Attorney General William Barr at the time, waged a public fear-mongering campaign to pressure Congress to permanently extend class wide policy through legislation.

This included an op-ed that William Barr penned in the Washington Post falsely claiming that all analogues would become legal and flood the streets if Congress allowed the class wide policy to expire. Trump's Department of Justice campaign also recruited U.S. attorneys to place op-eds targeting members of Congress to ignore concerns about class wide scheduling that had been raised by the civil rights and criminal justice community and others. The Trump's Department of Justice also organized a letter from the Attorneys General from all 50 states, highlighting the lethality of fentanyl and analogues and pushing for the permanent class wide legislation, again, putting Congress in a very difficult position.

Next slide please. In response to President Trump's Department of Justice pressure campaign, Congress extended class wide scheduling of fentanyl analogues for 15 months. This extension expires on May 6th of 2021. Congress granted this extension believing proponents of class wide scheduling who claim that one--doing so would reduce the availability of fentanyl analogues and overdoses involving fentanyl analogues; two--the Department of Justice needed new laws to use for prosecutions involving fentanyl analogues, and three--the Department of Justice would only prioritize people at the top of the drug distribution chain, rather than the bottom.

**Sheila Vakharia:** So, what actually happened. On the point on the first point about overdose deaths, what we can say is that the most recently available data from June 29 through May 2020 already contradicts that.

Even after class wide scheduling fentanyl and fentanyl analogue involved overdose deaths have only increased. This here is a map that shows the United States during the 12-month period. All of the states in the dark maroon are actually states that, during the course of that year saw an over 50% increase in that 12-month calendar period in overdose deaths and, as you can see, those states are predominantly to the west of the Mississippi. This is a fairly new development in terms of the overdose crisis and where fentanyl and fentanyl analogues are emerging in markets.

The remaining states in red are ones, in which the overdose deaths involving fentanyl and fentanyl analogues increased by 25 to 49% and then the light orange also saw increases. For the second point that we needed additional laws to capture fentanyl analogues and to prosecute them, we already had legislation on the books that made fentanyl analogues that were harmful already illegal and subject to harsh penalties. As already very articulately explained by our opening remarks, you can see here that the Controlled Substances Act, which was passed in 1971 and which has seen amendments over the years already included, as you can see to the left, on all scheduled drugs, including scheduled analogues dimensional analogues such as an acetyl fentanyl and carfentanyl.

And the point about emerging harmful fentanyl analogues, we do have the Analogue Act, which is also embedded within the Controlled Substances Act which allows us to, it to identify harmful fentanyl analogues that should be subject to other penalties. So, as you can see, the Controlled Substances Act already contains enough provisions to allow for the prosecution of these analogues. What we also know, is to the third point about the need to go after cartels and transnational criminal organizations, which was constantly used as a talking point, is even that point didn't come to fruition. Looking at the Sentencing Commission data from fiscal year 2019 on the data that was just made available, just a few weeks ago, who was actually being sentenced under these new fentanyl analogue provisions of the total people sentenced, we can actually see that the vast majority, almost half 45%, were actually just simply street level drug dealers and this. This so-called targeting of trafficking organizations, cartels and high-level kingpins, actually they comprise a smaller segment of those who were prosecuted.

**Grant Smith:** Thank you, Sheila. So, what kind of penalties are on the table for the street level sellers who've been disproportionately targeted? As was mentioned, classified scheduling involves thousands of substances some that have no effect on the central nervous system, all have varying levels of potency.

But all are subject to the same severe mandatory minimums. It takes just a detectable amount, a trace amount of an analogue within 10 grams of another substance to trigger a five-year mandatory minimum. As illustrated on the slide, 10 grams is the equivalent in weight to 10 paperclips. It's also worth noting that a trace amount of fentanyl analogue present in another substance that equals less than 10 grams can also trigger up to 20 years in prison. Similar to what we've seen in crack prosecutions, with fentanyl, it takes small amounts to trigger a harsh mandatory sentences and street level sellers are facing the brunt of federal prosecutions.

Also, when you look at the next slide at who has been prosecuted for fentanyl and fentanyl analogues, it's disproportionately black people who are locked up. So, we want to close this panel with these remarks from Missouri Congresswoman Cori Bush. Ms. Bush gave these marks at a House Judiciary Committee hearing exploring this topic, just last week. The congresswoman's remarks epitomize when we must be extra vigilant against repeating mistakes of the past, like the crack era. While we must learn from these mistakes and pursue science and health-based approaches to fentanyl and fentanyl analogues instead of letting fear, racism and carceral approaches drive policy. Thank you.

**Recording of Cori Bush:** The vicious carceral drug war that has prioritized punishment over treatment, violence over healing, and trauma over dignity,

**Sheila Vakharia:** has influenced all of our lives. Growing up in St Louis I saw the crack cocaine epidemic rob my community of so many lives and I'm not talking about what I heard or read, I'm not talking about what I watched on television, I'm talking about the people who are, who I was around. All the time people who I knew and was in community with, loved ones I saw picked off and put into a system that was this revolving door. I lived through a malicious marijuana war. I think that we should pass along the mic to the next panel, but, as you can see, I think Rep. Bush's comments ring true today. And I will stop.

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## **PANEL 1 | CLASSWIDE SCHEDULING IN THE FEDERAL CRIMINAL LEGAL SYSTEM**

### Panelists:

**Premal Dharia**, Institute of Mass Incarceration

**Jeffrey Lazarus**, Assistant Federal Public Defender, Northern District of Ohio

**Shantae Owens**, Vocal-NY

### Moderator:

**Kara Gotsch**, The Sentencing Project

## **TRANSCRIPT**

**Kara Gotsch:** I want to welcome my colleagues for the next panel to unmute yourself and show your screen. Wonderful. Good morning, everyone. Thank you so much for joining us for this event sponsored by the Ohio State University, my name is Kara Gotsch and I'm the deputy director at the Sentencing Project and it is my privilege to be moderating this next panel on the class wide scheduling of fentanyl analogues. So as was so clearly articulated we are in the midst of an overdose crisis because of opioids and because of the role that fentanyl and fentanyl analogues have played and have infiltrated drug markets. What we know, though, from decades of the war on drugs and research, and lots of experiences on the ground is that that the traditional response of the war on drugs, a punitive over criminalization response, has caused often more harm than good. So, what we hope to do in this next panel is to dig a little deeper to hear about the impact of in consequences of the current scheduling process. And how it's impacting communities how it's impacting incarceration levels, and we hope to have time at the end for questions. And I will be monitoring that so please, if we do have some questions as we go along, I hope to get to a couple of them at the very end. So, I'm going to start with our first panelist Shantae Owens who's a community leader with Vocal New York's User Union and he's an outreach worker providing harm reduction health services across New York City. Welcome Shantae. So, I want to ask start with a question with you for you Shantae. Your personal experience with drugs, including losing loved ones to overdose really provides an important lens on the impact and consequences of the war on drugs. How does the expanded criminalization of fentanyl analogues impact your community's safety and health? You're muted, can you unmute yourself?

**Shantae Owens:** You hear me?

**Kara Gotsch:** I can hear you now, wonderful.

**Shantae Owens:** Yeah, so it impacts my community in a number of ways. I've witnessed a lot of overdose deaths doing conducting street-based outreach you know arranging access and other supplies. My biggest concern is the fear, the fear of people no longer reaching out to seek harm reduction services if this were to come to pass, and why that is because I'd like to go back into reminding folks about how hard it was for us during the Good Samaritan law, giving out the Naloxone and putting it in the hands of people who are first responders. We had a hard time fighting to get people understand that it was it was a very important to call 911 in response to an overdose, to stop it from becoming a fatal overdose. We have finally got folks to being comfortable with calling 911 in response to an overdose. And my only fear again is that, should this come to pass, that we will just spend all that hard work, people will go back into not seeking harm reduction service. Overdose is going to continue to rise, as it has continued to be doing, and people are not going to want to seek to call 911 in response to an overdose and those overdoses can be fatal. We will lose a lot more people.

**Kara Gotsch:** So, thank you for that Mr. Owens. You know, in your experience with fentanyl analogues and what you're seeing on the street, did people who use or sell always know fentanyl analogues or fentanyl always even know it's present in the substances that they're taking or the substances that are selling? What have you seen?

**Shantae Owens:** Well no. A lot of the people that I'm, I come in contact with during my outreach they don't even know. You brought up a good point. They don't even know what's in it. It's not like they're in the lab. These folks have gotten it. the most of them a lot of them sometimes it's more like a trade, they're, they're distributing that to support their own substance. So, they don't know what that has fentanyl. And they don't even understand what, what, what that is. And that brings about the fear again. Folks are dying. Folks are dying at an increased rate. You know it's; the community is already being destroyed with overdose deaths that we already have on here and more will come, my fear is more will come if we do not do something to combat this overdose crises that we're already in.

**Kara Gotsch:** Do you think people are aware of the penalties associated with fentanyl? You said that, though, a lot of people don't know that they are there sometimes in the drugs either they're using or they're selling. Do you think the average person even knows what the criminal penalties might be associated that they're higher if there is fentanyl present or fentanyl analogues are present?

**Shantae Owens:** No, I, I really don't believe that they understand or even know what that is. And it's hard to try to explain it to folks because you know, our individual, whether we choose to believe it or not, is really seeking help. And the criminal justice system, you know don't they don't really want to go through that avenue you know. And that puts on a greatest strain on their life which will hinder them from reaching out for help, because they think that'll probably be a minor possession charge, and then they can find themselves in a federal institution, you see what I'm saying? That'll make folks totally disband... where even a lot of times I am like to hell with its man, I'm not even going to harm reduction, now I don't need, they don't need that added stress and they life.

**Kara Gotsch:** Absolutely. I think some people might respond that way you can also get treatment in the criminal justice system. Do you think that's a good alternative for people who might be seeking treatment?

**Shantae Owens:** I don't think that that that will actually work. I am coming from being incarcerated, it's forced help. A lot of times it's harsh, it's very harsh. And we got to remember that folks are already come to us with very low self-esteem, self-esteem levels are very low. A lot of folks deal with depression. Institutions only deal with the with the substance aspect of it, not the overall of the person, the trauma that they've experienced in their life. So, no I don't believe that will help.

**Kara Gotsch:** Thanks, Mr. Owens. So, I want to move on now to Jeffrey Lazarus who is a public defender in the Northern District of Ohio and he's, which is one of the areas of the country really hard hit by the opioid crisis and he's the assistant federal public defender. Prior to his work with the Federal Public Defender, he was also with the Cuyahoga County Public Defender's office and Cleveland. So, Jeff I want you to talk about federal prosecutions that you're seeing in your area in Northeast Ohio and because they're increasing for fentanyl and fentanyl analogies. Why is that and what has been your experience, the experience of your clients facing prosecution in these cases?

**Jeffrey Lazarus:** Yeah, thank you very much for having me. Here in the Northern District of Ohio, we are either the number one or number two district in the whole country in fentanyl analogue prosecutions and we really started to see an uptick in the numbers, beginning in the summer of 2018 when I think it was then Attorney General Jeff Sessions enacted Operation. So, this was a federal law enforcement program targeting certain cities to focus for federal prosecutions for fentanyl analogue cases. One of the 10 cities was Lorraine, which is the suburb, or the county just West of the Cleveland area. Lorraine had seen a huge number of opiate addicted people and a large number of opioid related deaths and it was identified as one of these targets' cities. So, this led to our U.S. Attorney's Office deciding to enact a number of a state prosecutions into federal prosecutions. So, people who were charged with heroin or opioid or fentanyl or fentanyl analogue crimes in the state, in the State Court, were then diverted into Federal Court where a U.S. attorney decided to charge them. The result was a huge jump on the number of federal prosecutions here in northern district Ohio we've seen that be pretty constant over the last two and a half years. The result of that is that our clients are facing statutory mandatory minimums and sentencing guidelines ranges that just completely dwarf anything they were facing in the state. It's our belief that these prosecutions cast an extremely wide net and isn't consistent with the goals of Operation SOS. We really see too problematic areas of these prosecutions. The first one is that our US attorneys are prosecuting very low-level drug traffickers. These are street traffickers not kingpins not even mid-level people, but just people on the street selling to confidential informants or getting stopped for a traffic stop that happened to have a small amount of fentanyl analogue. I have had cases that where we see someone who is been charged with just two grams of fentanyl analogue. And we are not saying that these cases shouldn't be prosecuted, but they should remain in the state, which is where we believe the penalties are more consistent with the with the crime and the truth of the matter is that many of the defendants that I have are people who are drug addicted to opioids themselves and are only selling these drugs in small amounts to feed their own habits. Had they continued to be prosecuted in

the state, they would have an opportunity to seek drug treatment as an alternative to prison, but when they are prosecuted federally there's no ability for treatment. Almost all my clients in these cases are going to the federal bureau of prisons, but more importantly, their sentencing exposure is far greater than they would have seen on the state level. In addition to the mandatory minimums that they face their sentencing guidelines are two, three, four even five times as great as they would get in the state. The other area that we are seeing is defendants who are charged with fentanyl analogues only because of small proportion of the drug that they were selling was fentanyl analogue. I am seeing a lot of cases and I've had a number of clients where they were a cocaine dealer or they thought they were selling heroin but someone at some stage in the process, some level not much higher than where they were, was cutting these drugs and because of the widespread availability of fentanyl analogues, and because of its cheap price, was using fentanyl analogues to cut the drugs. So even though my client thought he was selling an ounce or an ounce and a half of cocaine, it happened to contain point 0.1% fentanyl analogue so, then the whole bag is treated as fentanyl analogue and now my client is facing a five-year minimum and is facing sentencing guidelines that far exceed that whereas they would be facing a much more manageable sentence under state crimes. I also wanted to talk about the disparate impact that we have seen in these prosecutions because of race. You know, keep in mind that the state and federal law enforcement is picking and choosing which defendants are facing state charges and which one should be sent to Federal Court for increased prosecutions. For example, Lorain county, this target city, has an 85% demographic of people who are Caucasian and only 9% of people in the county or African American. But to contrast that every single client that I have had out of Lorain County who was been charged with a fentanyl analogue is African American. So, you know, we believe that, because the U.S. Attorneys are picking and choosing which defendants go to Federal Court that it the fallout is that it happens to have a severe racial disparate impact.

**Kara Gotsch:** Thank you so much. You know, can you talk a little bit Jeff about what happens at arrest, and so we know that mandatory minimums subject people to long periods of incarceration once they're convicted but what's happening to folks prior to their conviction, just when they're under arrest, are they in... What is the experience of your clients there?

**Jeffrey Lazarus:** So, in Federal Court not everybody gets a bond. If the prosecutor decides that they want our clients to be held without bond either because there are risk of flight or an alleged danger to the community, then they can be held without bond for the entire duration of their case. In federal drug cases I think it is 94% of all federal drug cases carry a presumption of detention, which means that the judge will presume that our clients should be held without bond, simply because it's a drug case. So, as a result here in the northern district Ohio about 60% of our clients are in pre-trial detention and must stay in detention for the entire duration of their case. And it is much higher in federal drug cases and it's even higher than that for cases involving analogues. So, this is very different from state prosecutions that in a State Prosecution, a defendant could post bail and could go into drug treatment in order to treat their habit or could go back to work or could go back to their family. But the pre-trial detention rates here in Federal Court are so high that it is, resulting in a lot of our clients being locked up in and feeling a sense of hopelessness, as their case draws near. Yeah absolutely. So I

want to move around a little bit and we'll come back to you Jeff and we'll come back to Shantae, but I want to get to our next panelist to sort of reflect on everything all you both have been saying about the impact on communities on your clients on your neighbors and friends of these sentencing federal approaches to drugs and law enforcement and so I'm bringing I want to bring in Premal Dharia who is in the inaugural Executive Director of the Institute to End Mass Incarceration at Harvard Law School. Welcome, thank you for joining us. And this will launch, that program launches this summer. But, most recently, she worked towards systematic change by founding and directing the Defender Impact Initiative. So, I want to give you to give us sort of a big picture Premal. So, you've heard what Shantae, and Jeff has said, you know. How did we get here? Why is this sort of our reality? Why are the feds leading the charge in prosecuting low level drug cases and why is fentanyl analogue sort of like captured you know the drug du jour right now that lawmakers or the Drug Enforcement Administration seems so fixated on?

**Premal Dharia:** Yeah, thank you for having me, and thank you to the other panelists for such helpful and insightful comments. You know I think I mean there are a few big picture reasons we are here; you know one is political rhetoric right. Which is not grounded in evidence and is very much grounded in misinformation, as some of the prior speakers have highlighted. And we're also here because of entrenched racism right, these are the realities, and we need to be, we need to you know be start being much more honest than we have been I think about a lot of this misinformation and the racism. If we think about the war on drugs in the history of the war on drugs, going back to its origins, you know a lot of it was very much intended to criminalize people and not conduct, right? So, I you know it started with sort of efforts to criminalize Chinese immigrants and then moving to criminalizing black men and then moving to criminalizing you know Mexican Americans and Mexican immigrants and now you know with respect to fentanyl analogues and prosecutions, that entrenched racism has not changed at all and that theme continues.

You know in 2018, 77% of people prosecuted for fentanyl analogues were people of color. In 2019 68% were people of color. And these numbers are stark, and they are real and so we need to be talking about that that thread and theme as a real reason that we're here. And there's also a lot of political rhetoric, despite the fact that you know, tens of millions of Americans continue to struggle with addiction and substance use and that drugs supply and demand, have not decreased, and that community destruction and incarceration rates have increased we continue down this path of politicians amplifying rhetoric about the utility of the criminal punishment system as a way to address what's a public health crisis and public health needs, and I think Shantae spoke really helpfully about you know the public health costs here and the real community cost, and so you know we have three decades of evidence to show that that this kind of approach hasn't worked. And we have no evidence to support that it does work. And you know with respect to that, I just want to also follow up a little bit on what Jeff was saying about mandatory minimums. You know there has been no... despite sort of people having looked at mandatory minimums and wondered whether they work or not, the evidence shows that there's no measurable impact on deterrence, right? And yet, and yet here we are with politicians, seeking to expand the use of mandatory minimums despite the evidence showing that they don't do what they're

supposedly intended to do. Mandatory minimums also, which are you know potentially being expanded here and which we need to really guard against also, in addition to what Jeff was mentioning about bond and detention, create all kinds of coercions and pressures on people who are facing prosecution right people who are arrested, if facing mandatory minimum charges often feel coerced into pleading guilty to avoid certain kinds of time, they often police misconduct and police, you know, conduct kind of generally goes unexamined and unrevealed because there's no motions litigation that happens, there's no motion to suppress hearing that happens, all of these things that that are criminal you know due process sort of contemplates often don't happen because of the existence of mandatory minimums.

So, I just want to highlight that as well there's so many different ways in which the evidence doesn't support this kind of expansion and doesn't, doesn't support any expansion of the war on drugs and, in fact, supports the opposite. And yet we find ourselves here again. You know it's interesting because the President, the current President Joe Biden, you know ran on a campaign of ending mandatory minimums but here he you know in his first few months is confronted with the Drug Enforcement Administration, you know, presumably, or we don't know exactly what their position is going to be, you know but, if continuing the class wide scheduling beyond May 6 means essentially that it will be expanding more substances, making them eligible for mandatory minimums, how do we reconcile the sort of this duality of you know, not just the current President, but this in recent years, this bipartisanship around at the federal level around drug mandatory minimums and the need to reduce them yet we're still having sort of a similar conversation over and over again about having to rearticulate why mandatory minimums are so harsh for drugs and that they shouldn't need to be revisited and here is an example of it going the other way. How do we, how do we understand that in this current bipartisan sort of narrative that we also are part of?

**Premal Dharia:** Yeah, I think that's a really great question, um you know, there is, I think, a growing consensus in our country, at least among community members, if not among politicians, that we can't incarcerate our way out of this crisis or any of these crises, but certainly not the public health crisis that that faces us here. And yet, and yet, politicians turn to incarceration.

You know it feeds into this sort of alarmist, popular imagination, that the media has helped to build, that politicians have helped to build, about how to address problems that we have, and you know, I think that there are so many organizations, right now, and so many advocates who are doing a wonderful job of telling the truth right of telling the honest truth about what this really is, and that this is not evidence based, it doesn't work and in fact it's causing great harm and there are alternative, concrete alternative solutions that are grounded in public health. You know Drug Policy Alliance has put out a number of you know very thoughtful concrete policy options for addressing these harms and so you know I think it's a question of more and more people listening and talking about the truth, the truth of lack of evidence and the truth of the racism and the truth of the fact is a public health crisis and change in the media and narrative around some of these things to. We need to start calling out politicians when they're when they're providing misinformation, as in you know the b=Barr op-ed that was discussed earlier.

Just, it's clear misinformation and I think that the more that we can provide public education and opportunities for people to grasp it the truth, which is very clear, the more we can do that. Great thanks,

so much. So, there are a number of questions in the Q and A, and I wanted to try and get to some. I see some I'm going to try to navigate, ask questions and read the questions at the same time. So, and I'll throw these out for either any of the panelists to answer but I'll start with one, the first one from Eric Sterling, which is, says: "Isn't inevitable that creating sea level targets for prosecution is going to lead to street level prosecutions if the international supply is the target the investigation should be based outside the US, yes?" What, does anyone want to answer to that you know what the feds as Jeff has pointed out in the opening discussions of pointing out they're disproportionately going after street level prosecutions and you know that local law enforcement can certainly handle.

**Jeffrey Lazarus:** I mean, I was gonna say, I mean the reason that the federal law enforcement is getting involved and what they think the street level prosecutions will lead to moving up the chain, that they'll be able to get the mid-level people, and the mid-level people will provide cooperation to the higher-level people and that it'll eventually move up the chain, but you know it's not working. You know clearly, it's not. I mean it works in some cases, but very few in the grand scheme of things and but what they're doing is they're really casting, in my opinion, too wide of a net. They're getting people at the lowest level and really throwing them in prison for you know 5, 10, 15 years with a goal, that is not achievable. I mean, I think the idea of trying to do prosecutions outside the country, I mean it is really an issue that law enforcement should probably endeavor but starting at the local level just seems very counterintuitive.

**Kara Gotsch:** Thanks. I have another question from David Jimenez. Is there, is the problem in these circumstances, and we talked about this with Shantae, and Jeff also mentioned this, how folks don't know fentanyl analogues are in the substances are selling. So, his question is, is a problem that men's rea requirements in federal sentencing are far too inadequate to begin with, or does emergency scheduling distinctly weaken those protections?

**Jeffrey Lazarus:** I think I would agree that the mens rea requirement is a problem. Under, at least in our circuit, you don't have to prove, if you're a prosecutor for having a fentanyl analogue, the government doesn't have to prove that you knowingly intended to distribute fentanyl analogue, they just have to prove that you knowingly intended to distribute a controlled substance. So, and I've had this in other cases, where we've litigated the idea that my client had an intended to traffic powder cocaine, which has you know, is a much smaller sentencing exposure than a fentanyl analogue that happened to be a part of substance that he sold but that's inadequate if they just have to prove that there was any legal drug involved and then he's accountable for the most serious element of the controlled substance that's in there, so that there, I mean we've litigated this, but the law was not on our side right now.

**Kara Gotsch:** Thanks. Anyone else want to respond to that? Okay. Here's another comment from Eric Sterling. The "contains a detectable amount" is absurd. Carrying over description of the circumstances that are drug enforcement strategies from a century ago. There were explicitly targeted on persons who use and who often were sentenced to the Federal addiction hospital in Kentucky in Lexington, Kentucky. An important reform is remove... from his perspective, an important reform is to remove the "any detectable amount" language from the Controlled Substances Act. Any thoughts on that you know the

trigger quantities around mens rea, fentanyl minimums having this as Eric characterizes “absurd.” Thoughts on that?

**Shantae Owens:** Yeah, hello, this is Shantae. Yeah. I think, I think, the point was brought up greatly that we’re missed, I think, somehow missing the point is that you know the point of it probably, the start was to catch the big fishes that have been the focal point for decades, but that just hasn't been the outcome. The outcome has always been catching low level offenders who are actually trying to support their own habit themselves, and now they find themselves in a more horrendous circumstances where they're now facing 10 to 15 years in prison. I think the point of it is that the science has shown that does not work. They continue to show it does not work. We need to do better; we can do better.

**Kara Gotsch:** Thank you, Shantae. Shantae, do you want to tell us the audience a little bit about the work that you're doing as an alternative approach to the current situation around opioids and fentanyl analogues in particular? As an example, is you know, what we can do better in our response to the, to drugs?

**Shantae Owens:** Well, what I would suggest that we can do... harm reduction has been shown to work. Syringe exchange, linking people back into care, whether it's hep-c navigation testing. But there's other things that we can do like I was saying, when I feel that we can do better. Even though pharmacies are allowed to sell a participant syringes, there's a limit on the amount that they can sell. I believe that we should do away with that limit. A person should be able to purchase as many syringes as they would need. Um that helps just prevent the spread of HIV/hep c which is shown for a person to get through sharing needles. Because our agency and most harm reduction centers, harm reduction programs close on a weekday, the weekend, I mean, excuse me.

And so, folks are kind of forced to get whatever supply they need by Friday. That doesn't count for Saturday and Sunday. So, then, the question is, what do I do. Do I wait till Monday? Cause a person is not, nine times out of 10, is not gonna wait to Monday, when our agency open back up. I would say that it will be more helpful like with the VOCAL outreach team we supply individuals with 10 pack bags, which has got sterile syringes, cookers and injection supplies, and they also included a voucher where they can go to a pharmacy and purchase additional syringes, should they need that access. We also should start, I believe, it was briefly talked about, we need to start having a conversation.

**Kara Gotsch:** mm hmm.

**Shantae Owens:** We need to start being honest and having a conversation. Look, we all know that this is here and it's affecting almost every neighborhood not just here in New York City, in Ohio and Philadelphia. It's almost everywhere. But we need to stop with the hush, hush not in my community, not in my backyard. We need to start being more honest with ourselves. And saying, look our people are dying, family members are dying, we are losing our humanity. How can, we need to come together as a community, because I believe that it takes a community to raise a child, and you better say what can I do, how can we help overcome this overdose. Again, for us incarceration has not worked. I come from a product of being incarcerated. I can honestly say that I am the person I am today through harm reduction. I'm getting case management, which helped me get into, back to employment, job searching,

getting my GED, starting a GED and moving up getting the education, becoming a person employable today.

That has worked for me and I go out on the streets and other folks have told I run into countless, countless of participants, that said hey I got my stuff, my life together through harm reduction. Again, I think we need to be more open with ourselves and start the conversation. We need to have the conversation.

**Kara Gotsch:** Well certainly having you talk about your experience Shantae and being on this panel is really an important first step in having that conversation. I think traditionally the response, the policy response, has been you know there's been a single policy response from lawmakers, which is punitive right? Locking people up. We don't like a behavior; we're just going to lock it away and not confront it. And the issue is, we are in the midst of a crisis now an overdose crisis where thousands of people are dying and it's only getting worse.

And so, we've got to change because we have had this punitive approach for decades now, and it hasn't worked and we're in the midst of this crisis and we've got to try something new, and I think what you are talking about Shantae is so exciting about... and you, you know, serve as a model of how this alternative approach of harm reduction can work, so thank you. I want to go on to another question, this one is for Premal. This comes from Lex Coleman. To me the class wide over breadth of fentanyl analogues like the entire drug quantity tables simply shows how ineffective time criminal culpability to drug type in quantity really is. At the end of the day, aren't most of the prosecuted systems street level dealings.

**Premal Dharja:** Yeah, I mean I think absolutely. I think that there's been lots of misfires here right in terms of intent, stated intentions. And what the war on drugs and criminal prosecutions around drugs have led to and have resulted in. And only 14% of people incarcerated federally are so called leaders or managers in in any of these kinds of offenses right. So, I mean that's a pretty stark number that tells you who's being prosecuted and for what. And I think Jeff's earlier point about a lot of state prosecutions being taken up by federal authorities is another sort of you know, point along these lines which is just that there are often political motivations right that have nothing to do with really thinking about public safety or health in choosing how we prosecute these things, or how we classify them.

And I think another piece of this that sort of highlights a lot of the absurdity of implementation is the use of mandatory minimums attached to quantity. Right, the mandatory minimums which you know, frankly, the government has essentially conceded don't work in enacting the First Step Act and which evidence has shown for years don't you know effectively deter crime and are now being further tied to quantity in a way that's destructive and harmful. So, yeah, I think those are those are really good points.

**Kara Gotsch:** Thank you. Shantae, I have a follow up question for you. And this is from Andrew Kessler, he asked if you can be more specific around what harm reductions are most effective. What programs were you... what are you specifically talking about when you're talking about harm reduction programs that have made a difference in people's lives.

**Shantae Owens:** Yes, so uh. Like, what VOCAL are and the User Union, of which I am a great part of in being a community leader. It doesn't discriminate. It's made up actually of the active and former users who is, who is given a chance to sit at a round table and make policy decisions, to go to your local politicians and let them know what's going on in their city. Our syringe access. As everyone should know, you know, at one time HIV with skyrocketing.

We were losing countless, countless of people. Most of that was through sharing unsafe syringes. With the legalized syringe change program, it allow folks to come into and register for syringe exchange program, receive clean sterile syringes and injection supplies and it's brought that that trend in, it crippled it. There's case management. There's case managers at harm reduction where you can sit, again it's about dealing with the person that trauma the person has gone through. With a case manager and working through that stuff that bottom gut wrenching stuff that we don't talk about and bring that out, then, if a person is willing to be involved in a back to work force program.

Sorry. Hello? Sorry.

**Kara Gotsch:** I apologize, I was just trying to get my young son out of the room.

**Shantae Owens:** Sorry, that I thought that was my camera sorry. Yeah, those are, those are the processes that has helped shape my life and countless others, and if we start looking into new ways that that again may become scary to some like a safe injection facility. You know removing the limit on syringe access from pharmacies, expanding the naloxone training. These are things that, from our perspective, I believe that we can, we can really truly combat the overdose crisis that we are in.

**Patricia Richman:** Hey, this. oh, there's Kara.

**Kara Gotsch:** Thank you, I'm back. Thank you so much, Shantae. I have one more, I think we have time for one maybe one more question or two. So here we have one for either Jeff or Premal from Dave Borden. Are there any health consequences for users that have been observed to result from fentanyl prosecutions? For example, in pre-trial detention, what kind of drug treatment services might be available for people going through withdrawal might be an example. But if you have personal experience with clients or know of others that, or other examples that would be something you could talk about.

**Jeffrey Lazarus:** Well, I mean I'll say that most of my clients that are going through withdrawal have to do it in pre-trial detention. That, it's, it's very unfortunate and it's awful and to have to deal with that person, while they're going through that is very tough to watch. But you know I've had a few success stories that have really opened my eyes to how beneficial treatment can be. You know I had a client last year, who had a severe opioid addiction and he got in debt to his drug dealer and in order to pay off his debt was selling drugs in small quantities and making deliveries on his dealers' behalf. And he got caught up in it and him and his dealer got charged. I was able to get him on pretrial release, which is you know, a very rare circumstance for a case involving opioid crimes.

Got him immediately to drug treatment and he was in drug treatment for a while and then remained. He did outpatient treatment and it got to a point where he did so well that he was able to get him probation and he's been clean for about nine months now, and um but that's just such a small percentage of the

clients, we see even though so many of them should be having that opportunity to get into treatment, to clean themselves up, to show their sentencing judge that they can be trusted in the community and not go to prison. You know, when I was a county public defender, I spent time in the drug court. Cuyahoga County has a really good drug court program, which is an alternative to prison and it's an alternative to a prosecution they end up getting their case dismissed if they complete successfully. We don't have that in Federal Court here in northern district of Ohio there's no real alternative dockets or alternatives to prison, and you know it really, it's a binary choice of whether they're going to spend a lengthy time in prison or whether they're in that few categories of people who can end up getting treatment, but it's not widespread enough that I feel that we're making a difference.

**Premal Dharja:** Can I just add a couple of things? You know what I want to you know emphasize and highlight the importance of public health responsibility things, right? Treatment of course and safe spaces and you know all of the sort of things that Shantae and others have talked about is, I think the in the Drug Policy Alliance has like very clearly outlined policy responses for and for ways to address these things. I want to disrupt the idea that the criminal system, you know is or could be a source of any kind of public health response. You know it's a punishment system and while I think we can and should be focused on treatment and public health, I don't I think we need to really think hard about how that can be disconnected from the sort of carceral impulses of arrest, prosecution and jailing and as ways to proceed.

You know, in my experience in terms of clients who are arrested and detained pre-trial or serving sentences, but particularly in the pre-trial context the treatment options are minimal. You know and medical and health care options, frankly, are either non-existent or minimal. And I think the COVID pandemic crisis has really highlighted this right for much more of the country that maybe previously realized it. But, for you know, often people in withdrawal or given aspirin and put in solitary. Right, these are the kinds of responses that we get from carceral facilities and, and so I just you know, want to disrupt the idea that we can, we can or should be trying harder to provide more health care, through that system, as opposed to removing the idea of treatment from that and pursuing it elsewhere.

**Kara Gotsch:** Thanks, so much. So, we have about a minute left, I want to give all thank all of you for joining and participating in this discussion, it was really excellent. I do want to give you a moment each to any if you have any final thoughts closing remarks that you want to leave our audience with. Shantae. You're muted. You're muted.

**Shantae Owens:** Great. You hear me now? Yes, sorry yeah. I would just like to reiterate that we need to start having the conversation. There's a lot of thoughts out there, that people say already people don't--you might hear it all the time—these people don't want help. I can speak against that. I know these individuals do want help. I had an opportunity to go upstate with a mother, who lost her child to incarceration and got punished for smuggling medication to help save his life. That medication was taken from them, in which he died. So, um there's so many different other levels of examples. But again, we need, we need to start having the conversation. We need to have this honest, open conversation, no matter how scary might be.

**Kara Gotsch:** Thank you.

**Jeffrey Lazarus:** I just want to say thank you very much for having me. I appreciate the opportunity to discuss our cases and these issues facing my clients and our district.

**Kara Gotsch:** Thank you.

**Premal Dharia:** Same. Thank you for having me.

**Kara Gotsch:** Great, thank you everyone and enjoy the rest of our conference. Take care.

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## **PANEL 2 | THE BALLOON EFFECT: THE PUBLIC HEALTH CONSEQUENCES OF CLASSWIDE SCHEDULING**

### *Panelists:*

**Dr. Daniel Ciccarone**, University of California San Francisco

**Dr. Ryan Marino**, University Hospitals, Cleveland, Ohio

### *Moderator:*

**Dr. Sheila Vakharia**, Drug Policy Alliance

## **TRANSCRIPT**

**Holly Griffin:** Thanks everyone, and thanks to our panelists so far today. I just wanted to go over a few quick notes. Just to streamline the appearance, if you have it, if you're just joining us. The best way to streamline the appearance of today's event is to hide non-video participants. You do that by hovering over those three little dots for anyone not sharing their video yet. Second, just wanted to draw attention to the Q&A function at the bottom of your zoom window. That last panel did great being able to answer many Q&A questions. There may not be quite so much time for other panels, so we will do our best, as we move through. Third, just to note that we do have auto generated transcription at the bottom of the event, and you can click live transcript to adjust any of those settings. Finally, the event is being recorded and we will make available after the event. Our next panel, is The Balloon Effect: Public Health Consequences of Classwide Scheduling and I will pass it over to Dr. Sheila Vakharia.

**Sheila Vakharia:** Hi, everybody. Thank you so much for sticking with us today. I'd like to take a moment to introduce my esteemed panelists, so we have with us today, Dr. Dan Ciccarone, who is a board-certified clinician in family medicine and addiction medicine. And his position as Professor of family and community medicine at the University of California in San Francisco he has been principal co-investigator on numerous NIH co-sponsored or sponsored public health research projects, including his current heroin in transition study. He is a recognized international scholar on the medical public health and public policy dimensions of substance use, risk and consequences. he's an associate editor for the International Journal of Drug Policy and recently edited a special issue on the triple wave crisis of opioids, heroin, and fentanyl in the U.S. and I'll be inviting him to speak a little bit further about that. And

then we also have Dr. Ryan Marino, who is a medical toxicologist addiction medical, addiction medicine specialist and emergency physician in Cleveland, Ohio. Dr. Marino serves as an assistant professor at Case Western Reserve University School of Medicine, he received his MBA from University of Pittsburgh School of Medicine. So, as we kind of kick off this panel I'd actually really like to invite Dan, Dr. Ciccarone to give us a little bit of a grounding in the current overdose crisis within the broader context of overdose trends in the United States. I gave a brief glimpse in my earlier remarks, but Dan has some really interesting framing to offer us in terms of really looking at this current moment, so I am going to share a slide that he gave me access to kind of set the stage for our conversations so go ahead and take the mic. I can't hear you. I'm sorry I don't know if anyone else can hear you.

**Daniel Ciccarone:** Can you hear me now?

**Sheila Vakharia:** Yes, excellent, thank you.

**Daniel Ciccarone:** Alright, sorry about that. So, hi everyone and good afternoon. Happy to be here, thank you, Sheila. So, to start us off, I just want to show you all the bad news. I mean we're talking about bad news, we're talking about increased overdose deaths, but we also have a short timeframe, we also have a timeframe of well, what is the drug of the moment, what's the one that's causing us problems right now? What's, what's the current scare, what's the current moral panic, if you will, and fentanyl does fit into the paradigm of a moral panic. But I want to know just step back and show you the bad news, the bad news of deaths due to drug overdose over the last 40 years or actually 38 years. If we look at the picture on the left, we can see drug mortality curves for various drugs and this you see a little bubble here another wave there and it all seems to be escalating. Now, if you look at the curve on the right, you can see that escalation. It is an exponential curve. This is a, this is the worst-case scenario in public health, where you see a disease entity that not only is increasing year by year, but it's increasing exponentially, year by year. And what this tells me is two things, right, and they're both bad news. One is that there's an unknown driver of drug overdose in the United States, right? There's something that we don't pay attention to that either because we haven't recognized it yet or we simply have a blind, a blind side to it. And that blind side I'm going to hypothesize is social, economic, racial injustice, social and economic disparities in this country that drive drug use, drive drug potency and drive overdose deaths. The second thing I'm going to say and again its bad news is what could possibly cause a 38-year exponential rise in drug overdose? Is that as our drug policies are actually making the problem worse. We're actually putting fuel on the fire, okay? That by trying to do mass incarceration, by trying to do a folly of drug supply controls, we've actually made the problem worse. And so, with those two I'll say that's my opening statement, and I look forward to more questions.

**Sheila Vakharia:** Thanks, so much. So, also within this context, Dan I am going to invite you to speak a little bit further, because there's a few constructs and theories that I'd like for you to also kind of bring to the awareness of our audience. First and foremost, you are kind of highly cited as the person who really started pushing us to thinking about this crisis, at least in the current moment as a triple wave crisis. Can you explain what you mean by the fact that we are in a triple wave crisis and perhaps already in the fourth crisis? What does that mean and what do you think contributed to that?

**Daniel Ciccarone:** So, the triple wave is the last 20 years of that 40 years crisis. The first wave of overdose deaths are due to the opioid pills. Where we're well aware of that phenomenon, there was an oversupply. The pushers were the corporations, making and manufacturing and distributing the opioid pills. But then we tried to clamp down on it so again a classic supply side paradox, where we put a lot of supply side pressure on reducing physician prescribing, we sued a lot of the manufacturers and distributors. We've cut back on the volume of pills that reach Americans by over 40%. And so, we see a decline, a leveling off if you will, of opioid pills, but what does that push, what is the balloon effect? That is the title of this panel today. The balloon effect was driving energy toward heroin use, distribution heroin use and heroin deaths. And then the fentanyl wave comes in as a third wave. This is a relatively new wave in this 20-year phenomenon starting around 2014 and fentanyl because it is a new substance, because it's, it's un... people are unaccustomed to it because of its potency and, and I'll argue further because of the vicissitudes in the number of analogues and their potencies, is driving an unprecedented, historic, rise in overdose deaths. That's the triple wave. The fourth wave is now stimulants are coming in being mixed with fentanyl usually through a choice, maybe some accidental mixing as well, and that's driving the fourth wave of overdose deaths.

**Sheila Vakharia:** Thank you so much for clearly just kind of articulating some of those terms and setting the stage for us. So, I'd like to now pull in Dr. Marino, Ryan, to speak a little bit about something that he is actually kind of gained a little bit of, a little bit of a reputation about in certain corners of the internet, in really dispelling and challenging and myth-busting around fentanyl. Wo you know some of the earlier presentations, mine included, today really just talked about some of the ways we've really you know framed and talked about fentanyl, its effects, and what it does. Can you talk a little bit about, you know, some of these, these headlines, about overdose based on physical just physical touch alone or inhaling it because it became airborne? And is really possible?

**Ryan Marino:** Yeah, so I think fentanyl myths and misconceptions have really kind of taken on a life of their own and without including them in the conversation around fentanyl we're kind of doing a disservice here. So, in my role in the emergency department, I can't say how valuable fentanyl is to me as a medication. In treating pain it's much more favorable in its effect profile than a lot of other opioids we use. And it's just overall kind of a great and indispensable medicine. But what I've seen recently and probably increasing over recent years is I will actually have patients now who come in, I mean maybe with a broken bone kind of poking out through their skin are turning down fentanyl. They don't want their pain well controlled they don't want kind of a safe and well-established drug and this is because of these myths that there are. And so, it's probably almost every day, at least once a week that we're hearing some sort of report someone is touching fentanyl, going down there's some law enforcement officer who was performing a routine traffic stop and had had all of these horrible things happen to them, and the only way they got better was they gave themselves Narcan or naloxone, the antidote. But the problem is that none of this is true fentanyl toxicity. And so, in my role as a medical toxicologist is knowing kind of how drugs work and understanding the pharmacokinetics, the chemical properties. And so, fentanyl does not absorb well through the skin. There is a fentanyl patch that's available on the market as a medicine, and this is not necessarily fentanyl per se. Its fentanyl mixed into a solution, it takes more than

13 hours to reach steady state concentrations in the human body, which would be a therapeutic dose not even an overdose and again we're talking more than 13 hours, and something that is not actually just fentanyl. And there's also this myth that it kind of gets into the air and can be aerosolized and fentanyl based on its physical properties and chemical properties does not do that well. And this is kind of played out into the scenario that this could become a weapon of mass destruction, and we have not seen this successfully weaponized, with the exception of one very questionable incident in Russia, these, these drugs just do not work like that. And so me and some other collaborators actually looked at the role of misinformation and just from May through December of 2019 there were 551 news reports in the United States that we found putting out misinformation about touching or inhaling fentanyl and of these 551 articles, which is about two a day, I think, based on that that sort of time period, there were 70 million Facebook shares or 70 million Facebook users were reading or exposed to those articles and inaccurate statements from government sources were actually shared 10 times more than accurate sources on fentanyl. And so, other people have looked at this phenomenon as well, and while these people are having true symptoms it's more likely to be a result of kind of the fear and the scare tactics, the overall kind of boogeyman of the day that fentanyl has become. And looking at these law enforcement officers, whoever has recorded these symptoms there's never been any testing that showed any fentanyl was in their system. People have done a very conclusive job at looking at the symptoms that are reported and they're usually actually the opposite of kind of opioid toxicity, where people get rapid rates of breathing and we know that opioids suppress your breathing. Increased heart rate palpitations, anxiety, fear these kinds of things that we actually use opioids to treat in people who are at end of life or having kind of severe medical issues we can use opioids to make you not have fear to make making not worried about your breathing. And so, none of this is consistent with opioid toxicity. This this myth is really out of control and for whatever reason, it keeps getting put forth as kind of fact when the facts show that it actually is the opposite and it's totally incorrect and false.

**Sheila Vakharia:** Thanks, so much Ryan. So, I want to pass the mic back to Dr. Dan, although Ryan, please feel free to jump in if you feel like you have something to contribute. I mean, Dan you've been in the space for decades now, and you've seen drugs du jour come and go, and you know drug hysteria or sensationalism come and go. Obviously, one of the comparisons that we are making today is often kind of harkening back to crack, but can you highlight some other instances of kind of drug sensationalisms, other drugs that have kind of, kind of came into public awareness, really only had you know, had a minimal you know geographic impact or very minimal impact, you know impact, all together, but that have had similar kind of stoked similar fears?

**Daniel Ciccarone:** Oh, there's plenty of them I don't know where to start, I mean, you know, a local one from back in the day was when MDMA came out. And MDMA a great drug. It's a wonderful drug people really liked it. And you know there were the raves there is, you know mass use all the sudden became like the thing I mean we have to think about you know, some one of the causes of these various drug bubbles and cycles we've seen is the fact that people like the drug, right? And everyone hypothesized it was going to cause this problem and that problem in the world, the sky was going to fall, and not much came out of the rave phenomena. Yeah, a few people got dehydrated and some people got serotonergic

syndrome and stuff like that, but you know we do often go, we have it, you know the society does have a philosophical, puritanical root to it. We do like to judge; we do get a little bit of bent out of shape. Now, I will say, based on my 20 years doing this, that there is a lot of concern around fentanyl. We're not making this stuff, up right. So, there is a genuine mortality curve here and mortality problem. The thing is, it's better than we are at this point. We can't pull out our old tropes about trying to put the genie back in the bottle, trying to strong arm other countries to do you know something that we want them to do. The truth, the real truth is, we have a demand concern in this in this country, a challenge in this country. We need to address this as a public health problem, we need to work on stigma to allow people to come into clinic sooner quicker. And we need harm reduction strategies as the gentleman from VOCAL-NY was saying so eloquently earlier because this brings people in and invites them in and then ultimately, we need policies that address the economic and social and racial problems of this country that are drivers. We need a long-term demand type solution to this problem.

**Ryan Marino:** Yeah, and just to jump in really quick here I mean, I think, I think, to emphasize what Dr. Ciccarone own said about the supply side only interventions, as well as this kind of fear mongering boogeyman approach. I mean we can look at cannabis as a much older example where the same thing happened, and we saw the development of synthetic cannabinoids. And in recent years, the more popular synthetic cannabinoids like K-2 and spice have had the same thing, where they are now banned, prohibited, at state and federal levels and people have moved on to newer synthetic cannabinoids that are having even worse consequences. This is something I see both in the hospital and getting reports through the poison center. Every new iteration is worse. And the same thing with the opioids, as we saw when you take away the pill supply, the prescription, they're probably while it wasn't ideal but they're safer than the heroin market and we've done a really good job of getting rid of heroin. And that was replaced with fentanyl and fentanyl analogues and so now, if we take away the fentanyl which I'm sure is totally possible, what is going to fill that void? It's probably just going to be something worse.

**Sheila Vakharia:** Thank you, and so you know all of these myths and fears really motivate sometimes really extreme policy choices, right? So, including the class wide scheduling, you know state level implementation and enactment of even harsher penalties, we see that. Can you talk about some of the other examples, and some of the ones that come to mind for me and I'm wondering if you'd be willing or interested in speaking about, is this proliferation of what we know of as drug induced homicide prosecutions and how those have actually also disproportionately impacted people who use on the ground and it feeds into some of this fentanyl sensationalism.

**Daniel Ciccarone:** Yeah, yeah, so, so our criminal justice policies related to drugs just lead to mass incarceration and it's been already mentioned it has a huge racial disparity in that we've locked up a couple of generations now. We lead the world in terms of incarceration of our population. It's a backwards approach. We are again, once again realizing that the backwards approach that it's not working, we need to try more enlightened approaches. There are other places that have far more rational approaches to drug policy that that lead people to treatment, who need treatment there's a lot of people who don't need treatment. They either find their way to reasonable levels of drug use and

pleasure seeking and not problematic levels. But those who do approach problematic levels places like Portugal, many places in Europe, will gently guide people over toward an open door, right? The problem with our approaches, just as a philosophical point is that, just adds to stigma. Stigma makes people run, it makes people hide, it makes people engage in more risky behaviors. A public health approach says we care for you, we invite you in, we're not going to judge you, right? And those approaches will increase the treatment population and lead to more personal and hopefully community-wide level successes. The issue we have right now is people say well isn't that also not working, Dr. Ciccarone? I mean would we give a lot of money to treatment; we give a lot of you know, some places, give a lot of money to harm reduction. The truth is just not enough it's just not enough. We don't have enough addiction medicine professionals, we don't have enough, a harm reduction programs, we don't give out enough needles, we don't give out naloxone, right? we have an evidence base that works, we need to ramp up this the, the policy side to meet the demand, and this is a historic level problem, so we need historic levels of resourcing.

**Sheila Vakharia:** Thank you, someone also say, and this, I think, goes along with this, but um you know, Dr. Bryce Pardo of the RAND Corporation, who recently, last year released a book on fentanyl. Some have argued that fentanyl is here to stay. What are some thoughts that you have about this, that this is kind of the new era of the drugs that are on the street that we're going to see more and more synthetic kind of substances, and that we're slightly, you know that we're moving away from plant, plant-based drugs? What thoughts do you have about that?

**Daniel Ciccarone:** So, I, I reviewed their work for them, I liked the book a lot, what Dr. Pardo and his colleagues at RAND have done. The one thing that we disagree on is one of the causal mechanisms, I actually think that I actually agree with the causal mechanism that fentanyl is coming as a substitute for heroin and remind you that we had a historic... if fentanyl never appeared, we would have had historic level of heroin use and heroin consequences, following the clamp down on the opioid pill phenomenal, right? So, wave two would have been historic all by itself, right? But instead, fentanyl came along, because there simply wasn't enough heroin to go around, believe it or not. And, and, and the RAND folks and I have a strong disagreement on this bubble, we'll see how the data falls over time. But fentanyl comes in because plant-based product is heavily pressured in terms of crop sprain and those kinds of supply side efforts. There's a limited number of source countries now. Some, some, some countries have gone away like, like the golden triangle of Thailand, Burma, Lau. Or at least have been greatly reduced so that limits the number of source countries producing heroin, so fentanyl come in as a technological innovation. It also fits into what we understand from studies of alcohol and other, other drugs that have supply side pressures and the iron law of prohibition and that is, as you put prohibition pressure on a drug class which produces greater potency. Fentanyl is the ultimate example of that. In the alcohol era, you put pressure on beer you create bootlegs hard liquor. In this case, you put pressure on heroin, and you've created a monstrous wave of dangerous drugs. And the thing is, we're putting you know the problem with the sentencing effort is that it's putting pressure if you put pressure on mother chemical, a mother fentanyl chemical, which is fentanyl you get 200, and some people have estimated as high as 600, fentanyl analogues that are out there right now. You put pressure on fentanyl

analogues, what happens? You're going to see synthetic opioids of other classes, of classes we don't we don't we don't know because we're just giving them numbers, like U47-700 and U98-900, you know? The ingenuity of the illicit chemical market is enormous, right? Why add more pressure to it? We should reverse that, get back to demand control, demand reduction and harm reduction.

**Sheila Vakharia:** Ryan, would you like to jump in at all?

**Ryan Marino:** Yeah, I mean, I think I would second everything that Dan just said. It is kind of the iron law of prohibition just pushes things to be more and more potent and I think we would have ended up at fentanyl regardless, is my personal suspicion. But when fentanyl came into the street opioid market, this was not something that anyone wanted. And I mean just to give an example of kind of the potency here, and this as a public health issue, what I was seeing in people who would come in, I mean primarily overdoses is what I would see in the hospital, not seeing people who are just using on their own, but it was about 50% pure heroin in in kind of heroin. With fentanyl replaced heroin on the market it's 1% fentanyl because it's 50 times more potent than heroin. When you look at that, in terms of kind of making the mistake that your average street level dealer is going to do, if you're off by 1% there that's an 100% increase in the dose of the drug and so it makes sense that we're having these massive overdoses, without anyone intending to do so. I mean an error of 1% when you're measuring things on kind of like a kitchen scale, in in someone's house or basement or whatever is not surprising at all. So, thinking of the legal consequences, the drug induced homicide charges, don't really make sense to me when this is kind of a minor human error that that we should expect, and it's a result of our own policy that we put forth for the past several decades, if not the last century, and so, in my eyes, I mean every drug overdose death is to the policy failure.

**Sheila Vakharia:** Thank you, thank you. Yes, that's such an important point. Dan, I'd like to invite you, for a second to talk a little bit about your heroin in transition study and some of the early papers that you released as part of it. Just kind of documenting and tracking when fentanyl began to emerge in some of these northeast and mid-Atlantic states and kind of the difference between what was happening then and what's happened now in some of those same exact entrenched markets in terms of, you know, the time being, that People didn't know what to expect, but now there are some markets in which the default is to expect that fentanyl is part of the drug supply. But can you talk a little bit about what you were initially finding in those early days versus kind of what some of the differences are now in terms of how people are talking on the ground?

**Daniel Ciccarone:** Yeah, thanks, Sheila. So, one of the notions we have about a drug cycle or drug wave, if you will, is that it's a popular drug. I mentioned earlier MDMA when it came out people decided they liked it and they told a friend and they told 10 friends and eventually became a cultural phenomenon. Fentanyl is not a cultural phenomenon, right? And I want to be very clear about that, I'm so clear about it that I wrote several papers just to be redundant about the notion, this is not demand side cultural wave of a popular drug, right? A lot of people in the early days when it came in, it was contaminating heroin, it was adulterating heroin, it was unbeknownst to low level dealers, unbeknownst to the users. People were surprised, people were dismayed by it, people didn't like it. And then, because of its persistence, I would say that popularity has gone from maybe one in five liking it or tolerating it in

their heroin to maybe double that maybe 40% now and that's because fentanyl potency drives demand for it, right, it is more potent than heroin. People's habits have gotten deeper, and people need the stronger drug now. That's one phenomenon. So slight, I would, you know not slight, but a doubling but an increasing popularity or likability or preference, if you will. But the other thing is, it is spread westward. There was a there was a moment of about four years' worth of moments where fentanyl was coming in as a supply side imposition, East the Mississippi river, so from Illinois on eastward, industrial northeast to the mid-Atlantic, certainly Appalachia and the end the Midwest upper Midwest industrial Midwest heavily affected by it. And that was, and we didn't know why, but clear at least to my historic brain was that it was a supply side thing. Some sub-cartel of some part of the Sinaloa cartel said hey, we're just going to do this and we're going to ride with it in these areas, right? But that moment has been breached. Fentanyl is now everywhere. It's moved to the American South and southeast. It's moved west of the Mississippi river. Differences, and this is still preliminary. More research needs to be done, as we, as we like to say in research. Fentanyl is being sold as if it's being marketed separately from the heroin separate from the opioid pills, and we need to understand the implications of that.

**Sheila Vakharia:** Yes, thank you. One other and thank you so much for tracking that and I feel like... also the math that I use to illustrate overdose increases over the past year have also helped to kind of illustrate that dramatic increase on the West Coast. The other thing that I want to highlight that I feel like you know, Shantae was kind of alluding to, that I'd like to hit home as well is that fentanyl doesn't have legs. People say that fentanyl doesn't have legs and it's changing their injection practices and their experiences of what it feels like. Can you talk a little bit about what it is, you know, what you're hearing from people who use on the ground, what it's actually doing to change their habits, their drug taking habits, which means that our harm reduction structures need to actually be more responsive to these changing dynamics?

**Daniel Ciccarone:** This is, this is where it gets complex and interesting and I, and I hope I don't bore the audience at all, but you know fentanyl is a short acting drug. It lasts 45 minutes to an hour and a half peak and Ryan can probably add more nuance to that. But when we use it, we use it, we I say we in medicine, we use it as a short-acting controlled, strong drug that if we run into trouble if either reversible or just the curve just goes away, right? On the street it's very interesting. We see both evidence of short-acting effect, where people in the early days were both kind of new it's kind of different people were injecting 5,6,7 times a day and that was very unusual. Heroin is a twice a day or three times a day drug. But, over time, people are injecting less frequently because it turns out that if fentanyl... chronic exposure to fentanyl has reduced renal clearance. And so, we're actually seeing that some people do find fentanyl has legs. And whether that's driven by individual genetics or individual pharmacodynamics is a little bit unclear. But it's a mixed picture. My point from worrying about as a person who worries about overdose, is that this, the chemical vicissitudes and fluctuations, and all this, whether it's going from fentanyl which is 40 times heroin down to an aceytalfentanyl which is three times heroin going up the carfentanyl which is you know hundreds of times heroin and then back to mother chemical fentanyl, whether it becomes a short acting drug to a long-acting drug back to a short acting drug. This is upsetting people's metabolism, this is, it probably hasn't proven yet, but hypothetically, it's a strong

hypothesis that the vicissitudes, whichever you driving by drug policy, by the way, our supply side drug policy, the vicissitudes in fentanyl are causing a lot of the overdoses because people can't adjust to the drug that's in front of them that day compared to what they were using yesterday or last week. Hope that was more clear than muddy.

**Sheila Vakharia:** No, thank you and so now, I want to shift to Ryan in the ER for a second. S, you know, you you've been practicing in the midst of all of this, you know what are some of the things that ERs can be doing better when responding to overdose and what are some of the broader pest policy lessons that you think that we should be taking to really push forward a more evidence based public health approach to working with folks who have experienced overdose or who are at risk of overdose? What are some things your ER does?

**Ryan Marino:** Yeah, I mean, I think there's a lot of things that we can be doing, and I think just first right off the bat some of the things that we shouldn't be doing is kind of perpetuating these myths and the stigma that Dan has also talked about. And the myths themselves probably come from a place of stigma, whether we realize it or not, and to perpetuate them is also continuing to increase the stigma. So, the idea that touching or breathing fentanyl that is somehow can be contagious or that you can overdose through a secondhand exposure is one of those myths. And so, I mean I see people who will not touch someone who has overdosed, they will not resuscitate someone who's overdosed. I've walked into a patient I was following in the hospital and saw staff members stuffing towels under the patient's door, because the patient had just overdosed in their room. And no one wanted to go in and resuscitate them and so those kind of kind of missed really scare me because it leads to a lot of real harms for human beings. And even if you're a little more cynical than that, this increases health care costs just through kind of the actual medical harms but we're now seeing things like fentanyl-proof glove being sold, fentanyl-blocking sprays, those kind of things. Which are all have no basis in science and are, I mean to just be frank here, are a total scam and made up. Things that we should be doing is kind of treating these people like anyone else, like anyone with any other medical condition and treating this as the public health crisis that it is. If someone has an overdose, we have a good drug that reverses most overdoses most of the time and that's naloxone or Narcan. And I think this should be I mean, first, it should be in every emergency department for sure, but it should also be out in the community. And then the other big thing that we can do is getting people linked into treatment a lot easier and things like buprenorphine and methadone, which buprenorphine has the brand name suboxone or Subutex, is those are probably the best things you can do for people who use opioids who are interested in in getting into recovery from them. And so that, I have a clinic where we prescribe medications for people who use opioids, and one of the biggest things that I see is that people, instead of getting into treatment, get taken to jail or prison, and so they don't get access to those medications and then they're left kind of out on their own. And this is a very vulnerable population to begin with, as we talked about a lot of times, I mean people are using because of a lot of socio economic, other kind of disparities in their life and taking away their one access point to an evidence-based treatment. is going to create a lot more problems and put them right back out there, where they're at probably increased risk of overdosing and there is actually good, good scientific evidence that shows that people who are incarcerated for, who

have opioid use disorder, whether they're incarcerated for that reason or not, when they're released from jail, have a much higher rate of dying than the general public, than people who are using opioids to do not go to jail, and then people who were released from prison or jail, who do not have opioid use disorder.

**Sheila Vakharia:** And could you can you talk a little bit more about the importance of using medication when it comes to treating folks and supporting folks, or providing them with an option for medications such as buprenorphine and methadone? Can you tell us a little bit about what's distinct about those medications and how they help people who have dependence, and what that impact can be when it comes to overdose prevention in the future?

**Ryan Marino:** Yeah, so if you think of kind of like addiction as a medical condition and for in a lot of cases it is it's a treatable medical condition. So, we have these two medicines: methadone or buprenorphine. And at the end of the day, the reason people use opioids, or the reason people develop addiction, kind of comes down to receptors in your brain. And so, these medications work on the same opioid receptors that heroin, fentanyl, whatever other opioid would be using, but they have more favorable profiles. And so, for methadone it's kind of a once daily thing. It will occupy those receptors. It prevents people from getting cravings, it allows them to kind of live their life, you don't have the ups and downs of something like fentanyl. And so, people can function totally normally as long as they get their once daily medication. And buprenorphine too is the same. It's usually once or twice a day. It's it just this on those same receptors and buprenorphine is a little different because it's actually not a not a full agonist so it doesn't have the same full opioid effects and can prevent people from having overdoses. But both of these medications actually prevent overdoses if someone were to have a relapse or recurrence of their use. They both, there's been studies that show people have changes in the parts of your brain that are affected by addiction, where their brain will go back towards where we consider to be more normal functioning if they're on these medications. And so, the big and harmful myth is that these medications are quote unquote just replacing one addiction with another. And that's not true because we can actually look at the functioning of someone's brain on a functional MRI and see that the center that was disordered while they were addicted to fentanyl has reverted back to normal functioning portion of the brain. On methadone or buprenorphine we see that people are having steady, daily functioning. They're able to kind of go out and have a job, drive their car, all that stuff. That that when you're on fentanyl because of the very short duration of action like we were talking about, you get kind of this intense effects and then very quickly it's out of your system and so over time that leads to withdrawal and your day is kind of spent trying to prevent that withdrawal. So, a once daily medication that prevents that and allows people to just function at a normal level, I mean it's like for me, and when I take my blood pressure medication, I'm not having the headaches and stuff that I would have. if I wasn't taking it. It's just like any other chronic condition. For people who have diabetes, they take their insulin they don't have to worry about kind of overdosing on sugar, so to speak. Where you can get very sick if your blood sugar is not controlled. It's really very similar for opioid use disorder.

**Sheila Vakharia:** Thank you. So, I'd like to ask you all about three specific harm reduction-informed policy proposals that we at DPA have been talking about extensively and I'd love for you to weigh in and

we even have someone asking about this as well. Um you know, in terms of other policy proposals that we could advocate for starting tomorrow, we drug policy alliance are talking about the need for safer consumption spaces or supervised injection facilities as a potential strategy and I'm interested in hearing a little bit about maybe kind of where each of you are at. But in terms of other really like on the ground, we can start with this immediately, are trials for other injectable opioids such as heroin assisted treatment or what is also known as hydromorphone assisted treatment and dilaudid. We've seen some initiatives around the world, with these kinds of policies. And then lastly, this idea of increasing access to drug testing equipment, so that people can be better informed about what drugs they are taking. Are either of you interested in talking about any of those policy responses and how you feel about them what they mean? I know we only have about seven minutes left, but I feel like again, in closing a public health panel, I think it's really important for us to kind of close with a public health solution.

**Daniel Ciccarone:** Right, you want to go first?

**Ryan Marino:** Yeah, so I mean I think when I see, Dan has mentioned this already, but seeing people who use drugs, not everyone has disordered drug use, not everyone has addiction. What the big problem is, is the drugs that are available on the street or unsafe and that's where fentanyl comes in, carfentanyl, we see all of these overdoses. One day, you might be getting a stable dose oxycodone, I mean years later you switch to a stable dose of heroin and then from one day to the next, you could be buying carfentanyl. And so that's how people die. It's not just from the consequences of being someone who uses drugs or from using drugs. So in terms of harm reduction, making things available like fentanyl test strips, and like safe use sites, no one has ever died in a site where their use is supervised. That that would be wonderful. In the hospital, we give people very potent opioids, we give people fentanyl analogues even that are more potent than a fentanyl itself, in anesthesia and these people are monitored very closely. They are on monitors, they have trained nurses there who can give them not naloxone, Narcan, if they have an overdose from these medications. And the same kind of thing is what we see in other countries where these safe use sites have been implemented. But certainly decriminalizing access to things like syringes that are still illegal in a lot of places and considered drug paraphernalia. Those kind of things go a long way. Most of the patients that I'm consulted on for addiction in the hospital are there, because they have some sort of horrible complication like an infection in the valve of their heart, just because they didn't have access to basic things like sterile water, a clean needle, or an alcohol pad. And these are kind of, penny, penny interventions that cost pennies that could prevent someone from needing 60 days in the hospital and open-heart surgery. So I think we really do have to kind of focus on that and, at the end of the day, if it isn't about kind of treating people better and being more kind to people who use drugs, there is a significant economic impact that comes into play here.

**Sheila Vakharia:** Thanks so much, Ryan, thanks so much. Dan, do you want to hop in?

**Daniel Ciccarone:** Yeah, Ryan, I agree with everything. So just briefly the evidence base for safer consumption spaces is incontrovertible at this point. Multiple countries, multiple studies over a couple of decades now, they work they save lives, nobody has died on site. They are only socially and politically controversial. They are not medically controversial. So, places that are willing and ready to do that

should move forward the Feds just need to get out of the way, frankly. The next notion that I would say comes under surveillance right, the idea that we understand the drug problem based on toxicology that people that have died. That is delayed data, that is sad data, its unfortunate data, but what we need is an understanding of how the drug supply is changing in the moment. Drug checking is a cheap, readily available technology for an individual use. I would also advocate for large, entity drug surveillance, so that a city or a county could know how is it's struck supply changing in the moment? This problem is not going to go away. Synthetics and the undulations, these vicissitudes that I've been talking about are not going away. We have shown using crime lab data from Ohio that if you understand the drug supply and its vicissitudes you can understand, you can actually predict overdose, you can send out warnings that says hey the fentanyl potency curve just got worse, this week, everyone be on guard. Safe consumption spaces will work. Surveillance

will help. Ultimately, we to level out the drug supply field, allow people to have more steady state in their brains that'll prevent overdose and whether we do that through hydromorphone prescribing or buprenorphine, which is a wonderful leveler or methadone,

will be up to our courage and our ability to think creatively. This historic crisis requires us to act more creatively and more boldly period. Thank you.

**Sheila Vakharia:** So, we have about two minutes left, are there any last remarks that either of you feel like you didn't get a chance to make? Anything that you, you have to add that just came to mind, or are we ready to pass it along to our next panel?

**Daniel Ciccarone:** I'll just jump in that you know stigma makes all this worse and criminal justice approach magnifies stigma, it harms people, it worsens the current situation, and if you know it drives this 38-year exponential curve that I started with.

**Sheila Vakharia:** Thanks, Dan. Ryan?

**Ryan Marino:** Yeah, I think, to reiterate everything that's been said, thinking of this as a public health crisis, which it is, this is tens of thousands and in in the past few years, hundreds of thousands of people dying. Every death entirely preventable. We need to treat it from a public health perspective. We shouldn't be treating it from a law enforcement and criminal justice perspective.

**Sheila Vakharia:** All right, well, thank you so much for everyone for tuning in, and I will pass it along now to Holly or Jana to keep things moving along. Thanks again so much, Dr. Marino and Dr. Ciccarone for your expertise today.

**Ryan Marino:** Thanks, Ryan. Thanks, Sheila.

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## PANEL 3 | CLASSWIDE SCHEDULING: THE EFFECT ON SCIENTIFIC RESEARCH AND THERAPEUTIC BREAKTHROUGHS

### Panelists:

**Dr. Patrick Beardsley**, Virginia Commonwealth University School of Medicine

**Dr. Sandy Comer**, College on Problems of Drug Dependence

### Moderator:

**Geoffrey Laredo**, Santa Cruz Strategies LLC

## TRANSCRIPT

**Holly Griffin:** Thanks again. For everyone who has joined us so far, and for those that have just joined us wanted to do a few reminders those include you can hide you're the non-video participants, just cleans up the screen just a little bit. We also have a Q&A function available. We do have a limited time for Q&A, but you are welcome to submit questions through that. We also have auto generated transcription. You can modify that at the bottom of your zoom window. And, finally, the event is being recorded and we will provide a link to that to all of our attendees today. Our next panel is panel 3 Class wide Scheduling the Effect on Scientific Research and Therapeutic Breakthroughs. And with that I'll pass it along to you Geoffrey Laredo, our moderator.

**Geoffrey Laredo:** Hi, good morning everyone from beautiful California. It looks Jana or Holly like you need to enable my own video. For folks... There we go and I apologize for a little bit of glare behind me. I'll try to turn myself around. Well that's, maybe that's a little better. I've been having some technical difficulties this morning, so I will apologize to everyone, ahead of time if I'm a little glitchy. And for any of the hosts, if this remains too glitchy please feel free to cut me off, and let the panelists do their thing. Thank you everyone for joining us today. I've really appreciated the remarks from all the previous panels.

My role here today as a moderator is mostly just to spend just a minute setting the stage for this topic, and then to get out of the way. I'm joined today by Dr. Sandy Comer of Columbia University and Dr. Patrick Beardsley from Virginia Commonwealth University and I'll let them introduce themselves in just a couple of minutes. In my little bio, if you've chosen to read it, you see, that I, I spent a lot of years working in the addiction research field at the NIH. Both at NIDA and at AAA. A lot of years. I am a 30 year, mostly retired Fed, for my sins, so I bring that both small "b" and capital "B" bureaucratic experience to this discussion. For several years before leaving NIDA in 2018, some slice of the schedule 1 issue was always on the policy agenda. You've already heard today, and you probably realize this because you're attending this conference in the first place, it's, it is a critical issue it's been a critical issue and it's always been some kind of a flashpoint whether, whether we like that or not. And for any of you there who know me, you know that I have a lot of opinions about this. Today, though I'm moderating this particular session, so I'll do my best to stay focused. bottom line for me from my years at NIDA, working with the research and working with the research community is that you know any class wide scheduling is going to hurt research, even more than schedule 1 already hurts the research enterprise. We could spend the rest of the day, talking about any even little slice of research of research

problems due to schedule 1. This is a, this is a big deal. So let me leave, let me let you hang right there. I'll turn this over to Sandy Comer who's going to provide us with a short slide presentation, where everybody can geek out on science for just a few minutes and then Patrick will add his thoughts and perspectives. Depending on the time available, I do have some questions that I might ask the panelists. We encourage you to put questions into the Q&A and like I said before, the hosts have been really helpful to me, and if my own tech fails us, they will step in and help us finish the session. So, Sandy, I'll ask you to take it away.

**Sandy Comer:** I'll share my screen. Okay, so, my name is Sandy Comer. I am a professor of neurobiology in the Psychiatry Department at Columbia University and my background is in in more basic kinds of research than what we've heard, up until now. So I just I love data so I'm going to share some data with you. And you know the topic of this is panel is why you know we as scientists are concerned about classwide scheduling. The you know, the first reason is that chemistry doesn't predict pharmacology and I'll explain what I mean by that in just a minute. And then you know, I guess, more importantly, in some ways, is that this this type of scheduling action could have pretty profound impacts on research and create barriers to developing medications for treating opioid use disorder. So, we've already talked about you know kind of what fentanyl is. I just want to reiterate Dr. Marino's point in the last panel that you know fentanyl is a very useful medication clinically. It's used routinely in the operating rooms for as a general anesthetic. It's available in various formulations for treating you know break through pain, for example.

And it's not you know pharmaceutical fentanyls that we're talking about here. It's the illicitly manufactured fentanyl. It can be synthesized from this substance, you know NPP, which is a very inexpensive substance. And through a couple of very easy steps, it can be used to create fentanyl and carfentanyl. So, there's a there's a very large profit margin for you know street chemists to make these substances. In terms of its pharmacology... so fentanyl differs from heroin, which is rapidly metabolized to morphine, and in a couple of really important ways. So you know both of these substances work at mu opioid receptors. There are a couple of sites that are important for their pharmacological action. Morphine produces effects preferentially at the G protein site, whereas fentanyl has greater activity at the beta-Arestin site. And you know in terms of how it, how it differs from the pharmacology perspective, fentanyl is more potent. We've already discussed that. It's more lipophilic and it crosses the into the brain much more easily. What we're really concerned about here from a public health perspective is we've described; you know just discussed earlier is you know the propensity for fentanyl and its analogues to produce overdose.

So these are some figures of fentanyl in the top, alfentanil, which is an analogue and remifentanil. So, each line represents a different dose of the substance and you know this is a measure of its effects over time. So, you know all of these substances can produce very rapid and profound decreases in respiration. So this is 10 minutes here, where you get these you know really large decreases in breathing. This is a study that was very recently published by Sean Flynn and Charles France showing that carfentanyl, fentanyl and heroin produce effects that are very similar. This is a procedure that is used to kind of model, you know drug effects and so all of them produce very similar levels of effect in

this particular model. This is a dose effect curve here so different doses along the bottom. Carfentanyl at much smaller doses will produce the same effect as heroin. And then down here what I'm showing you we just talked about fentanyl having no legs, this is what I think you're talking about. This is the time course of the effect here. Fentanyl is very short acting it lasts for you know, maybe an hour, maybe an hour and a half, so Dan is absolutely correct in that regard, whereas carfentanyl produces a much longer lasting effect. So, this figure using that same model shows that an opiate antagonist naltrexone, which is currently approved by the FDA and various formulations for treating opioid use disorder. So, what I'm showing you here is that the same dose of naltrexone that produces this pretty large blockade of fentanyl's effects is producing about a similar you know similar level of blockade for heroin.

What's concerning is that this same dose of naltrexone is not blocking the effects of carfentanyl quite as much and this is a concern for naltrexone as a maintenance medication, but it's even more of a concern with naloxone, which is the drug that's or medication that's used to treat opioid overdose. And we've seen in recent years an increasing number of clinical records demonstrating that higher doses of naloxone may be required for opioid overdose, and, especially against carfentanyl. And the reason why this may be happening is that there's a there's a non-opioid component of carfentanyl and fentanyl related overdoses. So what they do that differs from some other opioid agonist is that they have a high propensity to produce the chest wall rigidity and so this is not really reversed by naloxone because it doesn't act on these noradrenergic receptors. So, as I mentioned earlier, you know the reason that we're concerned about class wide scheduling is that chemistry doesn't predict pharmacology.

And very small changes to a chemical structure can make a potent agonist into an antagonist. So, an agonist is something like heroin or fentanyl and an antagonist something like naltrexone or naloxone. And this is a perfect example of that. So, the structure and red is the same across all of these different substances. This is oxy oxymorphone, which is a very selective, potent highly abusable opioid. And these tiny little modifications to this basic structure turns it into naltrexone or naloxone which have saved you know millions of lives. This is a from a very recent paper by Ivy Carroll a medicinal chemist showing the same thing. So, this is the structure offense now, and this is a fentanyl antagonist. So, it's very small modification that turns this into this that potentially could be very effective, maybe more effective than naloxone in reversing opiate overdose. You would think that you know something that shares a chemical similarity would be something that would be more effective in reversing its effects. In terms of legitimate you know medication development; this is another example. This is a compound mirfentanil which was under development, for you know for various indications, including as a potential maintenance medication for treating opioid use disorder. I received these slides from my colleague Chris Cunningham who's a medicinal chemistry and he wrote that you know as a chemist he would have expected me or fentanyl to have high abuse liability, but you know, Dr. Charles France, the author of that last study that I showed you, did some stuff pharmacology studies showing that you know mirfentanil may not have as high abuse potential is you know something like fentanyl. this compound shares the general structure of fentanyl and this would be captured as a schedule 1 substance, under the current class wide fentanyl scheduling order. Another area of research that could be you know impacted by the scheduling action is the development of vaccines.

I'm working with my colleague Dr. Marco Pravetoni at the University of Minnesota who has developed a variety of vaccines, including oxycodone, heroin, fentanyl vaccines. There are other investigators across the country Kim Janda, Gary Mattias who've also developed vaccines and the thing with vaccine development is that it has multiple components that basically have to be put together kind of like a puzzle and there are different manufacturing sites that will do that. So, not only would a schedule 1 license be required by you know someone like Dr. Pravetoni who developed these medications, but they would be required by the contract manufacturing organizations that would put the vaccine together. So, and this is what you know something that Dr. Pravetoni experienced, and it took months and months, for you know first, the CMO to agree to get a schedule 1 license. I mean there aren't very many facilities in the US that can do this type of work.

And you know willing to spend the money in order to you know meet the requirements for the schedule 1 licensing. In addition to you know those kinds of practical problems associated with putting substances into schedule 1, there are other you know more intangible problems as well. Because this could you know, this type of action could disproportionately affect younger investigators, who may not have you know luxury of having the collaborations with senior investigators who know how to navigate the process. Or investigators from smaller institutions that may not be willing to you know allow schedule 1 type research to be conducted at their facility because of you know of all kinds of regulations that are required. And Chris Cunningham, the medicinal chemistry I mentioned before, is from Concordia University, and this is something that he's encountered. So what do we need? We need a mechanism for differentiating agonist versus antagonist activity and we need exemptions from schedule 1 requirements for those conducting research with schedule 1 compounds. So, my colleagues and I have published this paper very recently in Drug and Alcohol Dependence, and this, you know just basically outlines what I just told you. Again I want to highlight my co-authors on this paper Dr. Pravetoni. Andrew Coop is also a medicinal chemist. Chris Cunningham and Mike Baumann from NIDA. And I'd also like to acknowledge the CPDD public policy committee as well as Ed Long and Katie Vanlandingham from Van Scoyoc Associates. So, thank you.

**Geoffrey Laredo:** Thanks, Sandy, very much. Patrick, can I ask you to make some remarks?

**Patrick Beardsley:** Well, thank you Jeff. A professor of pharmacology at the Virginia Commonwealth University and I've been involved with study of drugs of abuse, for over 30 years, both in terms of evaluating their abuse liability properties and for the development of medications for treating drug abuse problems. Well, like to make a few comments observations, some of which Dr. Comer didn't mention that I would like to expand on and some she did mention. My comments will only be restricted to the effects on research by class wide scheduling of the fentanyls.

Yes, I'm a researcher but I'm also on a committee for the World Health Organization, which makes regulatory recommendations for the international scheduling of drugs under the United Nations Drug Conventions. So, I view this present topic today, both from the eyes of researcher as well as someone who participates in the regulatory process. As a consequence, I have a few comments as a researcher, but I also have a few comments through a regulatory eye. My first comment is that it appears that history indicates that the DEA is able to keep up with the fentanyls, following the current process under the

Controlled Substances Act. Thirty-five fentanyl, have already been permanently scheduled under the current process. Eighteen of those fentanyl, have been scheduled just in the last two years. Just this month, 10 additional new fentanyl, were proposed by the DEA for permanent scheduling. Once those become permanently scheduled, there will have been 45 fentanyl, permanently scheduled under the current process. And here I'm not even mentioning the fact that all fentanyl related substances have been placed under temporary schedule 1 regulations, since 2018. And it's relatively easy for the DEA to place a compound under temporary schedule one conditions. All it takes to do so would be for a couple of in vitro test, maybe a couple of laboratory animal tests and some evidence of the scope, duration and significance of abuse of a compound.

Temporary scheduling of a compound lasts for two years that can be extended for an additional year, adequate time to gather evidence for permanent scheduling a compound. The bottom line here is that history and data indicate that the DEA can keep up with the festivals without needing new powers. The second comment I would like to make his that empowering the DEA with unilateral powers to schedule an entire chemical class of compounds, without input from the scientific and medical community, namely HHS is inconsistent with international practice and with our current governmental philosophy. It is inconsistent with international scheduling because that process, as described under the drug conventions of the United Nations, starts with the World Health Organization. WHO has a committee that conducts an intense scientific and medical review of a drug before our recommendation for scheduling is made to the United Nations. I'm quite familiar with this process for I've been serving on this committee for several years. It is important to note that American scientists and representatives played a major role in designing this process when the United Nations drug conventions were written. Empowering the DEA with unilateral powers to schedule an entire class of compounds without scientific and medical input on individual compounds is historically inconsistent with what America advised for the international scheduling of drugs and how drugs are presently internationally scheduled.

Secondly, turning over the power to schedule an entire chemical class of compounds to the Justice Department without input from the HHS also seems inconsistent with the current philosophy of the present administration that has repeatedly emphasized that science and data directs policy regarding the health and welfare of Americans. Class wide scheduling of drugs with send a signal to the international community that science isn't necessary for determining health-related policy in the United States and that policy can be solely determined through law enforcement officers and bureaucrats. A third point I would like to make is an expansion on a comment that Dr. Comer made. Research will be stifled by the permanent class wide scheduling of fentanyl, . In my past I worked for two different pharmaceutical companies. I'd find it doubtful that the pharmaceutical companies would be willing to explore the fentanyl, for possible therapeutics that begin with having a stain of schedule 1 on them, and that, and that incur the associated bureaucracy and security controls that are associated with handling them. It should be remembered that Paul Janssen of Janssen Pharmaceutica originally developed the fentanyl, because he saw opportunities to develop analgesics without the relative toxicity of morphine-like compounds. And there is definite hope in that regard. Dr. Comer showed us a couple, but also, for

example, University of Maryland scientists have identified a fentanyl-based compound that is a potent opioid analgesic but appears to have minimal respiratory depression effects.

If a drug like that could be validated and refined it would be a major breakthrough in health care because opiate-like analgesics kill by their respiratory depressant effects. Those same scientists also identified a fentanyl-based antagonist, that is an antidote, as powerful as naloxone for reversing opioid activity. This also could be a major breakthrough if pursued. Naloxone is currently our go to drug to treat opiate overdose. Naloxone has a chemical structure similar to morphine and heroin and is effective against those drugs. Naloxone isn't as effective against the fentanyls. Perhaps having an antidote based upon the fentanyl structure would be more effective in reversing overdose by the fentanyls. However, it's very unlikely that there will be interest by pharmaceutical companies in further exploring fentanyl-related substances, as safer analgesics or as antidotes to fentanyl overdose, if the entire chemical class of fentanyls were placed under the strictest regulatory control of schedule 1. Excuse me, a schedule 1. A related concern is a difficulty of moving a drug out from schedule 1 once it is placed in there into any other less restrictive schedule that is appropriate for a therapeutic. For example, only one drug has been moved from an initial schedule 1 classification into a less restrictive schedule in the last 27 years. The fourth point I would like to make is really a fear that I have. Empowering the DEA to permanently schedule the fentanyl class of compounds would be the tip of the iceberg.

There are other emerging opiate-like drugs of abuse that don't share in fentanyl structure. For instance, there are drugs based upon the drug etonitazene structure that have been referred to as nitazenes that have recently come to being abused. Once all fentanyl-related substances are permanently scheduled, do we then schedule the entire chemical class of nitazenes. And will it stop with the nitazenes? I would like to end with a personal anecdote with how class wide scheduling of fentanyls can impede spontaneity in research and research collaborations. I am working with a chemical engineer, who has this vision that he can create a patch much like the nicotine patch that can sense the presence of fentanyls in the body and immediately release opioid antidotes. We have a small internal grant for developing this patch, but our collaboration has been hampered by the fact that, although I am approved for handling fentanyls, he is still awaiting approval for his registrations. Obtaining a scheduled 1 registration can take a year or more. And he can't conduct research with the fentanyls because he's still awaiting this registrations. So, in summary, first there appears the DEA is presently keeping up with the fentanyls story under the current process and empowering it with new powers appears unnecessary.

Secondly, allowing the Justice Department to schedule an entire chemical class of drugs is consistent with how drugs are scheduled at the international level, as well as the present administration's emphasis on science and data driving the health policy for Americans. Third, research will be stifled, especially pharmaceutical research once an entire chemical class of compounds is permanently scheduled. And fourthly, I fear if the fentanyl says a chemical class or permanently scheduled to open the door to unbridled scheduling of other chemical classes of compounds, possibly hiding breakthrough therapeutics into a process that may never stop. Thank you.

**Geoffrey Laredo:** Thanks very much, Patrick. So, what I'd like to do is first to say Sandy, thank you for your presentation and giving us a little bit of the science background. Patrick, what I want to say, from a

science policy perspective to our audience here is everything he said take notes on every single thing he said. Watch the recording. That's your argument. It I think this is an illustration of why I enjoyed my job at NIDA so much working with folks like both of you. One comment from me and then some follow up questions from me and the audience. When I was at NIDA, I worked in the policy office. I'm not a scientist, I was the interface with the Congress and I'm a public health guy and reasonably knowledgeable on addiction science and it was my job to help translate a lot of what folks that you've all heard and seen today have been working on and lots of others across the field. I was told to my face by a senior DEA intervention policy person that I personally, and my colleagues at NIDA, were aiding and abetting drug dealers, by opposing the DEA's efforts to somehow regulate the fentanyl more than they were being regulated.

This was, this was a few years ago, so it was before the most current attempts at class wide scheduling, but it was basically the same discussion. So, I just wanted, I wanted to throw that out there and let that percolate into your brain, because that is: a) unacceptable, b) incorrect, c) completely crazy for a federal agency staffer to say to another federal agency staffer when you're allegedly trying to figure out difficult things. We know that the research community and the Drug Enforcement Administration are going to find plenty of issues to argue about. That's okay. But argue about them constructively as best you can. But that I just wanted to throw that out there, because it was an experience that I will never, ever forget. It was all I could do to maintain my own personal calm. Again for those of you who know me I don't take well to things like that. But it really shows the toxicity of some of some parts of this discussion. So, I'd like to ask a couple of questions first of my own of both Patrick and Sandy. Are there, in the work that you've done yourself, have there been specific requirements of any of the schedule one issues that have caused you difficulty in your work? From previous discussions that we've had your experiences have been a little bit different, and I think it's valuable for the audience to hear that. So whomever wants to go first.

**Patrick Beardsley:** I could comment on that, Jeff. Okay? Sure. Right, well. The present situation is really impossible for researchers. That is, there is this class wide temporary scheduling of fentanyl related compounds. Okay? Along with that, individual fentanyl compounds get permanently scheduled. So, when, in 2018 when all fentanyl related compounds were temporary scheduled, I went through a very intensive process of applying for permission to work with fentanyl analogues and I was granted permission and I obtained several of these fentanyl analogues to work with in my laboratory. In fact,

**Geoffrey Laredo:** Just how long did it take for you to get that permission was it a drawn-out thing or did it work well for you?

**Patrick Beardsley:** I'm an atypical case, Jeff, and I'll tell you why. Because at the time I had two contracts with the DEA to evaluate the pharmacological properties of the fentanyls.

**Geoffrey Laredo:** Fair enough.

**Patrick Beardsley:** So, I'm not sure if to get approved for working with all fentanyls is representative or not.

**Geoffrey Laredo:** You're a ringer, okay.

**Patrick Beardsley:** Yeah, I mean the important point is, is that there is a very intensive process of getting approved to work with all fentanyl related substances and I went through that. But now, when some of these compounds that I brought into my lab and have done research with, under the auspices of that permission have not become individually permanently scheduled and I have to go through the process, yet again for gaining permission to work with these individual fentanyls that have become permanently scheduled. In fact, I probably am holding some fentanyls illegally, because I initially brought them under the auspices of all fentanyls related substances, but now, some of these compounds have become individually scheduled and it makes it is just a bureaucratic mess and just enormous hurdles to keep up with the paperwork to do research with these fentanyls, under the current situation.

**Geoffrey Laredo:** Thank you. Sandy, do you have anything that you could add to that?

**Sandy Comer:** Yeah, I guess, I just want to thank you for sharing that the anecdote with your experience with a DEA agent. And just, you know, I just want to, I guess, maybe since we're being recorded, I want, I want to say that we're all on the same team, you know? The DEA, the scientists, we recognize this that this is a serious public health, you know issue. We're all incredibly concerned about it, and you know we're just working at it from different angles. You know, we as scientists are working so hard trying to find a an effective, you know antagonist for reversing overdoses to help you know, help when in those situations where naloxone is not working. We, you know, we're looking for vaccines that might you know, be useful, both for people who have opioid use disorder and also first responders who may be exposed to these substances in their line of work.

You know it's and the one is stymieing the other, and we have to figure out a way to make it work for everyone. So, I just you know, I'll just say that off the, off the you know at the beginning. So, in terms of my own research, you know, the example that I gave with the vaccine development is probably the closest you know where the, because I'm testing Marcos's vaccine right now, and there was a delay for about a year before the CMO was able to get the schedule 1 license and get you know everything in place regulatory wise in order to develop the vaccine. So, so, yeah, I've been you know very directly affected by this. There have been other you know investigators that I know in the field who have you know who've had similar problems and some of the very common themes that we've heard from the scientific community is the very long-time frame until initial approval, which is compounded by both state and federal licensing requirements.

There you know, as Patrick mentioned, there are delays with adding drugs to an existing license. There are communication difficulties. After you submit your application, sometimes it, you know people have told me that you know it feels like their application, you know, got lost in a black hole. They can't find anybody can answer their question about where their application is in the process. There, you know, there are practical difficulties and hurdles with regard to storage requirements. So, these are not insignificant hurdles. These you know storage requirements are expensive, and you know a lot of us,

you know researchers, are funded by NIDA and we can't you know build those kinds of costs into our grant applications. So, you know these are these are very real hurdles that we're facing.

**Geoffrey Laredo:** Thank you, I appreciate your we're all on the same team comments and that's exactly true and I do think, even with the process or bureaucratic hurdles that researchers have faced, it's my personal sense that in tone, if nothing else, things have improved over time. You know, NIDA were actually invited by CPD a couple of years ago, to have a joint a large joint session speaking directly about this issue to try to solicit more input from the research community. At the at the beginning, at least in my personal experience, at the beginning of this argument, both of both of you have talked about you know some things taking a long time, some things not taking a long time. One of the dirty little not so secrets at the NIH on specifically on this topic when I was there is many of you in the audience might know the NIH institute director many and agency directors have labs of their own, either at the NIH or elsewhere, whatever the arrangement they've made with the NIH.

Well, NIDA director Dr. Dr. Nora Volkow, of course, has had a lab for all for all of her years for all the years that she's been the director at NIDA. And she wanted to do research and get her lab to do research specifically on these fentanyl's starting a few years ago when it was becoming an even bigger problem for the country. And without getting into too many of the details, I mean think about this here's an NIH institute director, whose job it is to direct a billion-dollar agency to try to help figure out this problem, who has a lab of her own that she directs who is saying hey I'd like to personally try even more to do some of this work. That lab they had not sought a schedule 1 license prior to this, and it took that lab over a year to get licensed. So, the bureaucratic hurdles are real. I don't you know I don't have to be nasty about it, but it's been just process wise an extraordinary challenge for a lot of hard-working folks to try to figure out what to do. We have a question, a couple of questions in the Q&A that I'll try to get to here. The first if either of you have any comment on this it's from Christine Leonard and I'll just read it to you, there have been reports that zylazine mixed with fentanyl has resulted in a significant number of fatal opioid overdoses in Philadelphia, can you comment on this issue and the use of conventional overdose strategies for these types of situations? Does either of you have anything on that? It's not it's not exactly, yeah, it's not exactly on our topic, but I didn't want to just ignore your question, Christine. We can certainly try to get you an answer separately from this panel if neither of our panelists have that.

**Sandy Comer:** Yeah, let's do that. I'll definitely look it up and then get back.

**Patrick Beardsley:** It's an actual drug combination.

**Geoffrey Laredo:** Fair enough. Okay Christine, we will do our best to get back with you on that. There's a comment in the Q&A from Heather Harris that says the DEA is a law enforcement agency, not a scientific one. I'd like to make a first comment on that. I agree with you. I think that is 100% correct. The problem is that there is a huge chunk of what the DEA does where they actually are supposed to be, whether we all, like it or not, or agree with it or not, they are supposed to be a scientific agency. They do a whole range of testing. They have the legal authority to regulate pharmaceuticals. So, by law they actually are supposed to be a scientific agency. Lots of folks out there in the science policy world have argued for years that gee maybe that really shouldn't be their job, let's put that kind of work where it

belongs, in the Department of Health and Human Services, and you know, let the DEA, in fact, be a law enforcement agency. I'll leave it at that. I don't know if either Sandy or Patrick want to extend that comment.

**Patrick Beardsley:** Oh, I could comment, Jeff. Actually the DEA does have a scientific staff that reviews drugs during the scheduling process. I've come to know some of these, and they actually are very good scientists. At least in their past they may have been scientists, and so there is an aspect of the DEA that is equipped to do some scientific review.

**Sandy Comer:** Yeah, and I guess I just to add to that you know, like one of the one of my concluding points was that we really need to come up with a system for differentiating an agonist for an antagonist. You know, obviously, the definition of a schedule 1 compound is that it has high abuse potential and no therapeutic use. So, if you, you know follow this class wide scheduling and sweep up all of these you know substances, some which may not have any agonist activity at all, you're not meeting the definition of a schedule one compound. So, you know some from a very basic level it's you know I think it's crucial to identify what's an agonist and what's an antagonist. And this process that Patrick is talking about, is something that the DEA is currently using to characterize these you know these new fentanyl-like drugs. So, that process is already in place. And you know one thing that we haven't talked about yet is the eight-factor analysis that is required to you know, place a substance permanently into schedule one and that you know that's a very long conversation process. But you know what I was you know, suggesting that we do is use these really quick, simple kinds of procedures, like you know some of your procedures, Patrick I know are not simple, but it's relatively rapid, a relatively rapid process to do this kind of separation of something that's an agonist versus an antagonist.

**Geoffrey Laredo:** I think that's a really important point, and even just from an operational perspective Sandy you use the term sweep up and that actually triggered a memory of mine. You know when I, the first part of my involvement in this issue was several years ago, when there was actually proposed legislation based on some work that the DEA did to permanently schedule 340, 350 alleged fentanyl compounds into schedule one. And it caused a heck of a stir within HHS and NIDA and the Food and Drug Administration and DEA spent months working together, not always happily, but we worked through things because we on the health side could not figure out what even what many of these compounds were. So, there's an understandable and really challenging tension at the DEA between the scientific side and the law enforcement side, and I think that's that that is very real. And, at the end of the day, those three agencies were only able to agree on a couple of dozen of the compounds as ticking enough of the boxes. Like, do we really know what this is? Do we really know the chemical compounds? Is it as best we can all really tell and agree, is this really dangerous? Does it even merit a scheduling discussion? So, it points to the legitimate difficulty at least at the current bureaucratic construct at the federal level of how all of this gets dealt with.

**Sandy Comer:** Well, to circle back to the criminal justice, you know issue as well, that we discussed this morning, you can imagine that, with these you know class wide scheduling of these substances, sometimes you know these drugs are found in trace amounts and in you know other drugs. You know we talked about now they're being adulterated into cocaine or methamphetamine and then the

sentencing requirements are much harsher. You can imagine that if it happens that this one of these substances was an antagonist, and you know, but it meets the definition of a fentanyl analogue so it has no agonist activity, it will not get somebody high then somebody could be sent to prison for years on something that that isn't doesn't even have any abuse liability at all, right? So, then there's so many unintended consequences of this type of scheduling action.

**Geoffrey Laredo:** Yeah, and another challenge for all of your researchers there's another comment actually in the Q&A from Dr. Marco Pravetoni. It says one of the challenges, is that each state, and Patrick touched on this a little bit as well, each state provides different guidance on acquiring a schedule one or two license. And so, in his opinion centralization would probably help researchers and that's not the first time that somebody has said that to me and it's not again it's not a matter of the DEA necessarily intentionally trying to make people's life difficult. It's just a difficult and cumbersome process.

That, at the very least, it doesn't help the research community in its attempt to help provide some answers to a really long-term problem. So, I don't want to artificially cut us off, but I see on the clock in front of my face here its 10:45. So, I think I need to turn this back to the conference hosts. I want to thank you, Sandy and Patrick, for agreeing to be part of this, and thank you all very much for your attention. Thank you, thanks.

**Patricia Richman:** Thanks so much everyone, I have just been so excited this morning to see all of the different participants who have brought their expertise and viewpoints to this discussion and we're not done yet. We have two more terrific panels coming up after a 15-minute break. So I hope you can stretch your legs, refresh your coffee, grab a bite to eat and then come back and rejoin us at two o'clock when we're going to have Marilyn Mosby who is the State's Attorney for the City of Baltimore sitting down with Liz Komar from Fair and Just Prosecution to talk about how this looks through her eyes. And then we're going to close out today's discussion with a terrific panel of advocates, including Sakira Cook, Jason Pye, Kanya Bennett and Jasmine Budnella. So please take a break, take a minute and rejoin us at two o'clock. Well. Yes, two o'clock.

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## **PANEL 4 | FIRESIDE CHAT: A PROSECUTOR'S PERSPECTIVE**

**Liz Komar**, Fair and Just Prosecution & **Marilyn Mosby**, State's Attorney for Baltimore City

### **TRANSCRIPT**

**Holly Griffin:** Okay, welcome back everyone. And for those who are just joining us, I have just a few notes to share, about our event today. First, to streamline the appearance of the presentations today, we suggest that you hide non-video participants. You will do that by clicking on the three dots the top right corner of any participant box that has a video off and click hide non-video participants. Second, we want to draw your attention to the Q&A function at the bottom of the Zoom window. You may submit

questions at any time during the presentation. Please know, however, that there is very limited time for Q&A, but we will do our best to answer questions as we move forward through the event. Third, please note that auto-generated transcription has been enabled for the event. To change how you view the automated transcription or to hide it click live transcript in the menu at the bottom of your Zoom window. Finally, this event is being recorded. The recording will be made available on the event page and social media channels as soon as possible after the event. Follow us @OSULawDEPC to stay up to date on our research, programming, and future events. Our next panel, Fireside Chat: A Prosecutors Perspective will include Liz Komar and Marilyn Mosby and that will start here in just a moment. It looks like we have both of you here. I'll pass this along to Liz. Thanks.

**Liz Komar:** Thank you so much. And so I'm the director of strategic initiatives at Fair and Just Prosecution a national nonprofit which works to transform the criminal legal system by supporting elected prosecutors committed to a new vision of justice, and we have the privilege of working with State's Attorney Mosby. So, thank you State's Attorney Mosby for joining us and for anyone unfamiliar, which is hard at this point, on January 8, 2015 State's Attorney Mosby was sworn in as the 25<sup>th</sup> State's Attorney for Baltimore City, making her the youngest Chief Prosecutor of any major American city. After successfully completing one of the largest upsets in Baltimore City election history, she assumed office and immediately transformed the office into a national model for progressive, holistic prosecution. And as we talk, we'll talk about during this panel, a hallmark of her term has been her vigorous criticism of the war on drugs and her embrace of decriminalization and harm reduction as a path to improving equity, public safety and community wellbeing. So, thank you so much for joining us today.

**Marilyn Mosby:** Thank you for having me. Good to see you, Liz.

**Liz Komar:** Good to see you. And before we turn to our conversation, just a little background on today's convening for those who may have not attended prior sessions. So, the U.S. is in the midst of a deadly overdose crisis. Fatal overdoses have been on the rise, for several years, reaching a record peak of over 81,000 drug overdose deaths in the 12 months prior to May 2020. In response to that increase, in 2018 the DEA under President Trump decided that fentanyl analogues should be treated differently than other analogues. It used its temporary scheduling authority to take the unprecedented step of adding a class of substances that are structurally similar to fentanyl to step one of the Controlled Substances Act. This class wide ban means that any substance that the DEA deems to fall within the class definition is placed on schedule one with no scientific or health justification needed. Many analogues that either posed no harm to human health or could be therapeutic were swept up in the ban and are now subject to federal prosecution. After a temporary extension in February 2020 that class wide band now expires in May 2021. Meanwhile, federal prosecutions involving illicit fentanyl have increased more than 4,000% and roughly 75% of those cases have involved people of color. But those prosecutions haven't helped to tide overdoses. Synthetic opioid overdose deaths have in fact dramatically increased. In the 12 months prior to May 2020 synthetic opioids caused 38.4% more fatal overdoses than in the prior 12-month period. And so the unscientific fentanyl exceptionalism fueling this class wide ban should feel familiar because it echoes the crack cocaine exceptionalism of the 1980s. In 1986, Congress passed the anti-drug abuse Act, which created the infamous 100 to one powder crack cocaine disparity, dramatically

deepened and racial disparities in the federal criminal justice system, tearing apart, families and communities with no scientific basis. So I'm honored to have the opportunity to ask State's Attorney Mosby to share her thoughts on the impact of the drug war in Baltimore, her innovative drug policy reform work, and her insights on the just path forward. And so, turning to those lessons learned, in 2019 you testified before U.S. House panel and said, "there's no better illumination of this country's failed war on drugs than the city of Baltimore, Maryland." Why is that the case, and how have you seen that play out as a prosecutor?

**Marilyn Mosby:** So, I appreciate your question Liz and I said that in context of marijuana legalization, but it most certainly applies to drug policy more generally. Right? Since the era of Nixon, then Reagan, and for decades, we have fought a war on drugs, which was later professed to be by Nixon aid John Ehrlichman are really a war on black people. He professed that there were two enemies: the anti-war left and black people. And quote unquote we knew we couldn't make it illegal to be either against the war or being black, but by getting the public to associate the hippies with marijuana and the blacks with heroin, and then criminalizing them, that is important, criminalizing them both heavily, we could disrupt those communities, we could arrest their leaders, we could read their homes, we could break up their meetings and vilified them night after night on the evening news. Did we know we relying about the drugs, of course, we did. This is, this was, an aid to the White House at the start in the inception of this war on drugs that we're still fighting against. And that's exactly what they did, right, they were able to disrupt communities. And you look at a place like Baltimore, where almost 70% of the city's population is black. 28% of Baltimore's population lives in poverty. 35% of children live below poverty. There over 18,000 vacant houses, 16,000 vacant lots. The unemployment rate for young African American men between the ages of 18 and 24 is more than twice as high than that of whites. When you see cities like Baltimore, communities of color decimated by this war on drugs, you can't help but understand and recognize that the targeting, the prosecution, the tough sentences that were imposed, mostly upon people of color, contributed to the cyclical sort of crime driven by the collateral consequences of those convictions. So, you had children who lost their parents, to the system. We exacerbated then, exacerbating the poverty and most importantly, all of this approach they had absolutely nothing to do with reducing drug use. Right? And it didn't reduce drug use. So, one of my predecessors, and I highlight Baltimore because it is, you know it's a microcosm of what we've done. It's a perfect example of what we've done and how that failure of the war on drugs has been all across this country. My predecessor, Mayor and mentor, Curt Schmoke was a mayor in Baltimore in the 1980s. And he was one of the first leaders to realize the damage that they were doing in real time with this approach, and he stated America's war on drugs, was a domestic Vietnam. And he was vilified for that, right? So as my role as a prosecutor, I'm the one who decides who's been be charged, what they are going to be charged with, what sentence recommendations we're going to make. We determine whether or not somebody's going to get into the criminal justice system in the first place. Our mission is justice over convictions. And ethically, we are supposed to right the wrongs of the past. And so that is the approach that I've taken in this role and the approach that I think more prosecutors should across this country.

**Liz Komar:** Thank you. What have you been doing to write those wrongs?

**Marilyn Mosby:** So I mean there's a number of things that we've been doing and, in addition to taking a very sort of non-traditional approach prosecution. We don't have like a case processing office, right? We've taken a holistic approach. In 2019 this war on drugs was understanding the data, right? When we look at these issues, I was one of the first prosecutors in the country to come out and have one of the most progressive marijuana policies. I came out and basically said regardless of size or amount, regardless of criminal history, we are no longer prosecuting mere possession of marijuana. And the reason why is that we know that there's no disparate use among white and black people. However, if you're black in this country and you're four times more likely to be arrested for mere possession of marijuana. And in the City of Baltimore you were six times more likely. And even after we decriminalized 10 grams or less of marijuana, we, the 42% of the citations that were being issued were issued in one out of nine police districts, which happened to be 95% black and disproportionately impoverished. Well, I came out after you know, assessment, and we did a full white paper and justification with my team and looked at, you know what was happening legalization all across the country and what we realized is that there's absolutely no public safety value in this prosecution. Those places that have legalized there hasn't been a drastic increase in violence. They're counterproductive to the limited resources that we have in law enforcement. You know at the time, in 2019, our clearance rate was less than 26%, homicide clearance rate, meaning the cases that we saw. So we're only solving one out of four homicides. We should be using those resources for the bad, the really bad guys, not these individuals that are being indiscriminately enforced, these laws are being indiscriminately enforced against. And, last but certainly not least, to that point, you know I came out said I'm not going to be complicit in the discriminatory enforcement of these laws against poor black and brown people, while there are certain individuals who are making millions of dollars off of this industry at this point. I will no longer criminalize black people for this. And what we've seen is that the police initially was where resistant. I've worked with five police commissioners in five years, but they have gotten on board. And we were able to reallocate resources and to expand upon our homicide unit and we haven't seen a drastic increase, and that was one of the things that we did. We also have one of the first, I created a crime control prevention division within my office, to be able to break the school to prison pipeline, and to ensure that we're addressing the needs of those individuals that are stuck with a felony conviction. Because we know, once you get one you can no longer apply for a job, no longer apply for housing, can't go back to school because you can't get any financial aid and then what other reports, you have to go out to them what you're doing in the first place? So we modeled a program and created an Aim to Be More program and that was modeled after Kamala Harris's Back on Track Program, where we're taking young people, first time felony drug offenders, and allowing them to go through a probationary period where they learn life skills and job training skills, they do community service. And at the end of that probationary period they are given a job and that felony records of wiped clean. And, last but certainly not least, around this whole war on drugs, is that we focus on this past year, in March at the height of the COVID pandemic, we consulted with public health experts all across the country, and what we understood very early on, was that this jail, and it actually turned out to be true, is going to be an incubator for this virus, it had the potential of exacerbating the virus. And so we came out and looking at what was happening all across the country, following the George Floyd, and everything and even before that, but what we know is that

these low-level offenses have nothing to do with public safety. You look at what happened in George Floyd, right? You have an individual who allegedly passed a counterfeit bill during the global pandemic for groceries. You know we look at Eric Garner allegedly selling loose cigarettes. Sandra Bland failed to put on a turn signal. All of these low-level events is for black people in this country can end up being a death sentence. And so, what we did, and after consulting those public health experts, is to set our own decarceral guidelines. And we came out and we basically said we're not going to prosecute drug possession. We're not going to prosecute sex work and prostitution. We're not going to prosecute disorderly conduct and these low-level traffic offenses. Again for those individuals that can for black people in this country could lead to a death sentence, that has no public safety value, is counterproductive to the limited resources that we have. And so what we've been able to show from that data in the past year is that we've been able to reduce the number of individuals going in and out of the jail by 35% the number of progress, the police component with our policies, have decreased by 80%. And the actual violent crime rate has decreased last year by 30%. The only thing that stayed on the same par was the shootings and the murders, but they did not increase. They were on par with what they were before which, ultimately, we believe, is indicative of the fact that we should have never been prosecuting these cases and allowing the police to respond to every social ill of society and criminalizing these offenses from in the first place.

**Liz Komar:** Thank you. In our last two minutes, just to kind of tie this back to the theme of the convening, you know you do still treat fentanyl and fentanyl analogue cases very seriously. You prosecute them and, unlike many of the advocates of class wide scheduling who have falsely argued that ending it with somehow legalize fentanyl analogues, which is wrong, it's also clearly not your goal. So, why do you oppose class wide scheduling?

**Marilyn Mosby:** So, the one thing I will say is that we have to be extremely careful, right? We kind of learned our lessons before and we learned our lesson with the as you already mentioned the crack epidemic. We don't want to treat this, and this is a very bad substance that has affected not just inner cities in America, but the suburbs, which is possibly one of the reasons why we're talking about it from public health perspective and no longer looking to criminalize it in the first place, but we have to be really careful and learn from the lessons of the past. And so you know from that perspective, we need to treat it the same way that we do from a public health and perspective and a lens and a harm reduction lens. That's one of the reasons why you know I've advocated for safe injection sites. I had the awesome opportunity of being able to go with my colleagues from across the country to Germany and Portugal with Fair and Just Prosecution and to learn and see the impact of you know decriminalization of drugs, and that is something that you know their entire criminal justice system was totally different from ours. It was a level of respect and human dignity, dignity and quite candidly compassion, that we do not exhibit for those individuals in our country. And we, we should always harken back to the lessons of the past and remember the impetus of this war and the criminalization of substance use disorder, which is a war on black people in the war on drugs.

**Liz Komar:** Thank you State's Attorney Mosby. Thank you for your time today. And so, with that I'll turn it back over to the facilitators.

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## **PANEL 5 | THE WAY FORWARD: POLICY RESPONSES TO FENTANYL ANALOGUES AND DRUG CONTROL**

### *Panelists:*

**Jasmine Budnella**, Vocal-NY

**Sakira Cook**, Leadership Conference on Civil and Human Rights

**Jason Pye**, Rule of Law Initiatives, Due Process Institute

**Patricia Richman**, Federal Public and Community Defenders

### *Moderator:*

**Kanya Bennett**, The Bail Project

## **TRANSCRIPT**

**Holly Griffin:** Thank you, both. So, now we're moving on to our final panel of the day, The Way Forward: Policy Responses to Fentanyl Analogues and Drug Control. Following this panel, we will have a short sort of final message, so stay for that as well. And with that I will pass this along to Kanya Bennett. Thank you.

**Kanya Bennett:** Thank you so much, and good afternoon, good afternoon everyone. We appreciate you joining us, those who are tuning in for this afternoon's portion. For those of you who have been with us throughout the day, and it's certainly been a very thoughtful, very engaging, very deliberative discussion and I have the honor of closing the panel the symposium out with this panel on the way forward. Again, my name is Kanya Bennett and I'm a senior policy council and legislative policy manager at the Bail Project. The Bail Project is a national nonprofit that has been operating since 2018 to advance criminal, racial and economic justice by paying bail for people in need. As part of the Bail Project's policy team, I am pushing systemic reforms that will steer states and localities away from wealth-based detention. Obviously, the Bail Project is concerned with all things bail, all things pre-trial and the people impacted by these practices including those who are being jailed because of our reliance on punitive approaches to fentanyl and fentanyl analogues. Today's symposium has explored all that is wrong with this punitive approach and as I shared at the start, as today's symposium closes, we want to figure out how we move forward. I have the privilege of moderating a conversation about this way forward and what policy responses should look like and what they shouldn't look like, as we steer in the federal government away from class wide scheduling of fentanyl analogues and towards a public health approach. I'm going to introduce our panelists as I raise questions with them. We have a great lineup and I know we will have a very thoughtful conversation. Patricia Richman, who was one of the symposium conveners, is on this panel so want to give her a special acknowledgement for all that she has done, along with Grant Smith of Drug Policy Alliance and our friends there, Doug Berman and others at The Ohio State University for giving us this platform today and for allowing us to have this very important conversation. So, with that I am going to raise our first a question with Jasmine Budnella, who is the drug policy

coordinator for the New York based Voices of Community Activists and Leaders or VOCAL New York. At VOCAL New York, Jasmine leads state and city campaigns to end the drug war and to win policies that promote harm reduction and public health. She also facilitates End Overdose New York, which is a coalition of stakeholders from across the state who have been impacted by the overdose crisis.

Jasmine, the conversation that we've been having today is not new to you. In New York, you are pushing back against the prohibitionist's approach to fentanyl. You are instead asking state lawmakers to advance the health-based approach to fentanyl and fentanyl analogues. And I know that there's a lot that we can learn at the federal level from what you have been experiencing in New York. Can you talk with us for a few minutes about what lessons we can learn from your work there in the State of New York?

**Jasmine Budnella:** Sure, thanks, and super pumped to be here. Thanks again to Patricia and Grant for pulling this together. I'm really excited to be here. So, yeah just like a quick rundown of how we were able to push back against the state scheduling fentanyl at the state level of the Controlled Substance Act. One, is like New York often is said of a beacon of hope, right, like a beacon of progressivism, when really, it's like you know the Rockefeller drug laws were born in New York and our governor has, you know, continuously fought back against evidence-based solutions. So, for the last four years in our budget, the Governor has proposed to schedule fentanyl analogues as a response to the overdose crisis which is surging across the State of New York, really surging now during COVID. So, for the first year we were able to fight back and really work with the Senate and the Assembly to say hey we can't do this. But, for the second year we you know, which was the same year that New York State had passed historic bail reform legislation but were also running our campaign alongside what was happening at the federal level. So, we knew that it was both a narrative fight, a policy fight, and a political fight. So the narrative piece was that we were you know building with our coalition, the stakeholders from across the state, that is both rural urban, suburban families who have lost their loved ones, people who currently use drugs, service providers, of saying hey prohibition got us here and we cannot continue to oil the drug war machine as we move forward. Because we know what's going to happen, and you know the beginning of this panel, I was really pumped, or not panel but symposium, to see how you all laid out that like if we schedule fentanyl, we know that mass incarceration is going to increase. We know that evidence-based solutions and people's ability to use them, are going to decrease and overdoses are going to continue to rise. And so what we did was pulled together our legislative leaders and we just so happened to have a few of them who voted against the Rockefeller drug laws in 1973 and voted to repeal them, so we brought them in to say hey, this is the next level, and you all fought back in the beginning, we need you to fight back hard now. And essentially what the governor was proposing was that the Department of Health would have unfettered access to schedule any drug, right, as well as was proposing to schedule 30 analogues including salts. And we were able to really galvanize not only these legacy legislators who have been against the drug war since its inception, and bring together newer, the next level of new legislative champions, who were standing on the shoulders of these legacy elected to say like we cannot move forward in like, essentially, we cannot move forward to drug war 2.0. What we need to do instead is pass all this legislation. Which is overdose prevention centers across the State of New York, which is universal access to medication assisted treatment, which is universal access to

harm reduction tools. Right? And we need to realize that criminalization and prohibition is why we're in this mess, to begin with. And so we didn't win, but we didn't fully lose. What we won, right, was that we didn't have the Department of Health didn't get unfettered access. What we didn't win instead, well, partial win, is instead of 30 analogues being scheduled, they scheduled 13 that was alongside of what the federal government did. And so, the other really big narrative part is like bringing together that all of the voices, as well as legislators, is that not only this year did the governor not propose any criminalization tactics at all, which was a big, I think, narrative win, as well as some policy and advocacy wins, is that now you know we're like in an election cycle, as well as just had one, and everybody is, not everybody, a lot of people are talking about we need to be moving to decriminalization. We need universal access to medication assisted treatment. We need you know universal access to harm reduction. We need overdose prevention centers. We need to like move away from treating people with criminalization and harm and treat them with care and compassion. So and I was just talking about this today earlier, is that we had local, hyper local news saying the governor is taking a prohibitionist approach to the overdose crisis. So like that, I was like, wow, like the Albany Channel 7 is talking about it in this kind of way. And so I would just say that, like, framing in my brain about like how we are able to bring together multiple stakeholders, hold the spaces of both the narrative, the policy, and the politics as look, as well as looking at our champions, which many of them have been on this panel today, that it can inspire new leadership inside both you know the Congress and the Senate, as well as local governments.

**Kanya Bennett:** Thank you so much for that Jasmine. I was busy taking some notes. There's so much to react to and I think that it makes the most sense to turn to our colleague Sakira Cook who's at the Leadership Conference to do some of that response. You talked about sort of how your work there in New York state was happening in parallel to what was you know going on at the federal level and Sakira Cook is the senior director of the Justice Reform program at the Leadership Conference on Civil and Human Rights and the Leadership Conference Education Fund. She was previously the legal follow at the Open Society Foundations. At the Leadership Conference Sakira leads coalition work on policy that touches every aspect of the criminal legal system, and we are very appreciative to have Sakira's leadership in this space. Sakira is a partner with all of us on so many things, and obviously knows you know from over criminalization and over policing to increase prosecution and mass incarceration. What we have seen time and time again being used the tactics and tools of the criminal legal system, just how this is going to have impact if we stay this course with respect to fentanyl and fentanyl related substances. So Sakira, I want you to talk a little bit about how class wide scheduling perpetuates these failed tactics of the war on drugs. We heard a bit from Jasmine on what that looks like in New York. What does it look like at the federal level?

**Sakira Cook:** Well, thanks Kanya for that question, and thank you again to Grant Smith at EPA and Patricia at the Federal Defenders for bringing us all together to talk about this issue. You know, for the last several years, we've been pushing back on what we believe to be a return to the old ways of the past, I would say 40 years, that that this war on drugs has been in place. If we continue to approach drug use and abuse as a sort of enforcement through the lens of enforcement and criminalization, we

will continue to perpetuate what we have seen where crack and powder cocaine, what we have seen with other drugs, which is that black and brown people and other people of color will disproportionately bear the brunt of incarceration as a result of prosecution and a focus on immigration versus public health for these types of issues. And the mere fact that we believe that we can continue down this path and have a different result, in my view, is definition of insanity. We tried this over and over again for however long we've been quote unquote fighting this war on drugs and it hasn't made us any safer. It hasn't led to lower use rates. It hasn't led to you know decrease incidence of drug use and selling in abuse. And so, if that hasn't worked, why do we continue to take the same approach? Why do we continue to do the same things over and over again if not, for what you know prosecutor Mosby said, which is that the entire framework for how we approach drug use in this country has been built on, from our perspective, systemic racism, has been built on an understanding that our sole goal was to put black and brown people in prison? That is the sole goal of the criminal legal apparatus in this country, especially at the federal level. Almost half of the federal prison population are people there for drug offenses. That is not by accident that's by design, because of the ways that we have set up our system. So class wide scheduling of fentanyl will only continue on the path that we have said in the last 10 years or so that we are trying to move away from. We have said, we no longer believe that long sentences mandatory, minimums in particular, are the right approach to achieve public safety. We have said that we have worked to address those things both republicans and democrats have said that they agree that we have taken that this approach does not work, and it does not lead to safer communities and safer environments for everyone, but it has just led to more and more people behind prison, and more and more black people and brown people in prison. So, if we actually believe that if we are actually you know sort of want to take a different route, we should no longer find excuses for using age old adages around the war on drugs around our needs to use criminalization and enforcement as a mechanism and driver of public safety today. We shouldn't be doing that in 2021. And so, what we will see and continue, and have seen is prosecution and incarceration, which have never worked again as proper solutions like to public health issues, will you know, continue to be on the rise, will continue to see an overuse and abuse of mandatory minimums which serve no goal other than perpetuating the expansion of the criminal legal system, the expansion of the prison system, on the backs of black and brown individuals especially because of the way that policing and over policing happens in this country where police resources are predominantly pushed to excuse me, predominantly people of color neighborhoods. Fentanyl analogues have led to mandatory minimum sentences in the U.S. for years, for decades, but supply has only increased, it hasn't been decreased, so this isn't even working to stop the influx of the drugs into the country. And trends again reflect the tendency to treat this opioid problem as a deserving of criminalization of only certain communities, instead of the compassion and dignity and treatment that my previous colleagues just talked about. So, I mean we know that it is the case that many drug users or sellers do not actually even know quite frankly that the composition of the drugs that they're selling, that they are selling heroin, many of them do not even know that the heroin that they are selling is laced with fentanyl, that it has fentanyl analogues or any analogue in inside of it. They don't they don't know that. But they you know are charged with sentencing enhancements that again lead to mandatory minimum sentences. This is supported by U.S. Sentencing Commission data showing that the majority of those

prosecuted for fentanyl trafficking did not have clear knowledge that they were trafficking the drug. Class wide scheduling will not address this issue and will therefore just subject more individuals, as I said before, to involvement within the criminal legal system. That will have consequences far beyond just that initial conviction. And we again have seen this played out over and over and over again.

When I think about the hysteria and I, and I use that word, you know both like not lightly, but I use that word intentionally because it's, not to say that we all should not be concerned about the drug abuse crisis. We all should be concerned about drug use and abuse and overdose deaths. Absolutely. We absolutely should be concerned about that, but the hysteria, unfortunately, because of that concern, it turns into hysteria, that turns into policymaking, from our perspective, that has continued to use mechanisms and solutions from the past, from the time where you know, to some extent people didn't know better, but a time where many did not know better, but now we know, now we know we have data, we have research, we have proven solutions in the opposite direction that we know we can use, but we continue to want to go to enforcement.

And I have we have to ask ourselves why. We have to ask ourselves, is continued prosecution, increases in prison incarceration, increases in you know the numbers of people going to prison for trafficking in drugs that may or may not be laced with fentanyl or an analogue, if that is going to reduce the amount of fentanyl coming into the country, the number of other drugs coming into the country? Is it going to reduce overdose deaths? And we've seen it hasn't, it doesn't, it does not do that. But the things that do work, and you know my colleague talked about this earlier, that's what we should be focusing on. So, from our perspective, to continue down the road of criminalization, of over incarceration, of an approach to drug use and abuse in America that is rooted in you know, again enforcement and you know does not think about how we invest in other alternatives, how we invest in communities in community-led solutions from a public health perspective is the wrong way to go. It will only lead to what we have seen over the last three or four decades with respect to the impact of the war on drugs on black and brown people specifically and on our society as a whole.

**Kanya Bennett:** Thank you so much for that Sakira and, yes, we definitely want to circle back to what some of these public health approaches may look like. I was listening and paying close attention to what you shared as well. And this this sense of us knowing better as a society, as a country in terms of how we need to respond to drugs, drug use, is, I think, exactly why are we now need to bring Jason into this conversation. You also talked about this being a bipartisan issue. That there are people across the ideological spectrum that that know that we need to do better, and that, if we continue to criminalize drug and drug use, that we are going to find ourselves in in the picture that you so properly provided us. So, Jason let's talk to you now and let me introduce you before I have you offer some thoughts. So, you're the director of the Rule of Law Initiatives at the Due Process Institute. You're promoting the organization's policy agenda on Capitol Hill. Prior to joining DPI we all had the pleasure of working with you as Vice President of Legislative Affairs for Freedom Works.

And you know, in both capacities, you've been a part of this right, left collaboration to reform our criminal legal system. This push to end the war on drugs and the many harms that have come from it is owned by a diverse constituency and, as I said, both progressive and conservative advocates do not want to

repeat the mistakes that we have used previously when it comes to drugs. Crack cocaine obviously comes to mind. And now, we're talking about fentanyl and fentanyl analogues and again not wanting to head in that same direction. So, can you talk a little bit about class wide scheduling and how it undercuts these goals around bipartisan criminal legal reform that we've had some success with today?

**Jason Pye:** Yeah, certainly. And thank you Kanya and Grant and Patricia. Thanks for having me on and Sakira it's good to see you again. It's been a while. Hope you're doing well. I was reminded by some of the challenges that we faced just last week when the House Crime Subcommittee held a hearing on federal policies and enforcement related to the Controlled Substances. It had the potential to be a bipartisan discussion, unfortunately, the Republican minority really didn't engage on the merits of the discussion at all, such as the very real racial disparities in the criminal justice system. Instead, they spent much of their time discussing immigration and the border, very stereotypical, but rather boring at the end of the day. Almost every buzzword was mentioned at some point, either by republican members or by their witness who happened to be a former DEA agent. I even heard one republican member of the subcommittee speak positively about drug dealer liability laws in his home state. We do, we know that these laws do little more than target dealers who are the easiest to replace and they don't do anything to stop the flow of drugs in communities.

I'm 40 and it's been referenced already that the drug war has gone on for 40 years. It existed in some form, even before then, but we know that the war on drugs has been a failure. Yet here we are, fighting the same battles because too many have refused to recognize that addiction is a public health issue. Some may recall the 1997 movie *The Lost World*. If you haven't seen it, it's on TV almost every weekend. I'm sure you can find it on some station, in which the eccentric Jurassic Park creator John Hammond who wants to send a team to an island to observe dinosaurs tells Ian Malcolm I'm not making the same mistakes again. To which Malcolm replies, no, you're making all new ones. The same could be said of us as we approach the approach this part of this new phase of the war on drugs. Class wide scheduling undercuts the goals of bipartisan criminal legal reform and criminal justice reform by denying proper defense, due process, and it has also has a lot of mens rea concerns as Sakira mentioned, in terms of intent. This includes punishment of individuals who lack criminal intent and punishment of individuals for substances that have not been evaluated by scientists to establish that it even meets the criteria for schedule one. Potency and purity are also extremely varied across fentanyl analogues and yet the mandatory sentence is the same. Penalties for fentanyl are already very harsh and have been since the 1980s, the most they are among the most severe mandatory minimums for drugs, if not the most severe. But this has not deterred or stopped illicit fentanyl from coming into communities. There are thousands of federal criminal laws on the books. We should be focusing on reducing over criminalization rather than expanding the net of criminalization, in this case for drugs.

One of the issues also, this is kind of a separate but still one I'm very passionate about, it's its article one, the separation of powers. Far too many lawmakers, democratic and Republican alike, are willing to surrender their power to executive agencies. This is problematic, no matter what the policy areas, whether it's trade, war powers or classified scheduling. And that's because class wide scheduling concentrates power within one federal agency, the Department of Justice, and in one person, the

Attorney General, who would have unilateral power to add substances to the federal schedule and set penalties accordingly. The Attorney General should not, no matter which party that Attorney General belongs to, should not be granted broad power to schedule criminal sub- chemical substances. And, not to mention the fact that we also have extreme costs that come with it and that's perhaps an answer for a different question, but we should be focusing on the on this as a public health issue, not one related to incarceration and furthering those significant racial disparities that exist in our criminal justice system. And as someone who's made his career on the center right side of the aisle, and working predominantly with republican offices, I do wish more republican offices would recognize and acknowledge that those disparities exist and that the war on drugs has been a failure for more than 40 years.

**Kanya Bennett:** Thank you for that, Jason. And we'll certainly come back to you and try to figure out how we get more Republicans to the table, how we get. all members to engage with us here. I want to turn to Patricia as I shared at the start. Patricia Richman is largely responsible for getting us all here today, assembled for this discussion. She's the National Sentencing Resource Council with the Federal Public and Community Defenders, where she leads legislative and policy work. Previously, Patricia served as a detailee to the Judiciary Committee for U.S. Senator Richard Durban who is now chairing that committee. And she is also a former assistant federal public defender in Maryland.

So, Patricia I think the perspective that you're bringing to this conversation is so important. Obviously, you've done advocacy on the Hill and you continue to do that now for the Federal Defenders, but you, you have practice, and you know that as a defender and as a system actor, that that criminalizing fentanyl is much more than the conversation we're having you know today in the symposium, and the back and forth that lawmakers are going to have when they try to figure out next steps. So, you've experienced clients, many of them low level offenders, people of color, people in need of substance use treatment, who have felt the brunt of having a prison over public health approach to fentanyl. So, I think it really benefits this audience to hear sort of what you know due process, liberty and other real-world implications of class wide scheduling look like, what it looks like.

**Patricia Richman:** Thank you so much, Kanya and I really appreciate everybody's participation today. This has been such a great gathering to participate in today. And a lot of what it means to be an individual moving through the criminal justice system is feeling the brunt of extreme prosecutorial power, the brunt of the power of the government brought to bear and class wide scheduling double doubles down on this power. It unnecessarily expands the DEA and Department of Justice's authority in a way that truly undermines core notions of fairness. So, as an initial matter, we have to recognize that the Trump Administration's push for class wide scheduling has rested on two oft repeated false claims. One, there's a gap or loophole in law enforcement tools impeding the government's ability to prosecute these cases, their ability to seize the substances. The other one is that without class wide scheduling, harmful fentanyl analogues would be legalized. And as Bill Barr said in his infamous op-ed last year, legalized poison, the tsunami of legalized poison would flood the country. Both of these claims, repeated often, are untrue.

What we know is the DOJ and DEA mostly prosecute analogues that have been individually scheduled. Individually scheduled, as you heard in some of the earlier panels today, individually scheduled

substances can be swiftly controlled by the DEA but there's a backstop of scientific and medical evaluation before that control is may permanent, to ensure that that substance has no potential for abuse, that it has no therapeutic benefit. For the rest, the remaining handful of cases, the Department of Justice can use the Analogue Act. Now Department of Justice complains a lot about the Analogue Act being unwieldy and burdensome although, at the same time, it's acknowledged a good track record on these cases. But the burdens associated with the Analogue Act exists for a reason. The Analogue Act is the government's tool to prosecute substances that DEA and DOJ have decided are harmful, but nobody else has confirmed that yet. It's right for the government to carry a higher burden when they seek to bring the harsh federal penalties to bear against an individual for a substance that potentially no scientist or expert has concluded would be helpful. In any case, I've asked federal defender offices across the country about whether they've had battles of the experts or inconsistent court outcomes and fentanyl analogue cases and haven't learned about that happening. So, in criminal prosecutions, government attorneys have to prove each element of an offense beyond a reasonable doubt. Why is that the case? Because we live in a country that airs on the side of protecting innocence, or at least purports to. William Blackstone wrote better that 10 guilty persons escape than one innocent suffer. And together, the Analogue Act and Controlled Substances Act require that someone other than the Department of Justice confirm a substance's potential for abuse. But class wide scheduling eliminates those checks against over criminalization and overreach. It relieves the Government of its burden to prove that novel substances are harmful and eliminates the opportunity for medical and science institutions to weigh in, all using an approach, a structure-based approach that is not supported by science. And we know that the number of substances criminalized by this approach is unknown.

We know they're going to range in potency from harmful to inert. But under class wide control, any of these substances will be subject to criminal prosecution, even if the substance has no potential for abuse. And for those who say that these concerns are hypothetical, I will tell you, there are already examples of this occurring. The Sentencing Commission and their recent report found that 2.1% of fentanyl analogue cases it looked at involved benzylfentanyl which is a substance that has been known to have no potential for abuse, no effect in the human body, since 1986. If class wide scheduling becomes permanent, prosecutors are going to have no incentive to determine whether or not substance has abuse potential. And even if they were incentivized to do that, they don't have the tools to do it. Obviously, Kanya, criminalizing substances with no potential for abuse poses significant implications for fundamental fairness.

**Kanya Bennett:** Thank you so much, Patricia. I think we all really benefited from sort of hearing how this plays out in the real world, what the practical implications are for people. We certainly need to understand through humanizing this issue what's at stake here. You talked a lot about sort of what happens when we ignore our medical and science institutions, when we sort of leave them out of the policymaking here. And so you know, Jasmine, I want to go back to you, following up on some of what you shared at the start of this conversation about the need to really take a public health approach here, why it is critical that we have you know, medicine and science here you know at the table as stakeholders figuring out how we move forward. So, can you talk a bit about what that looks like? You

know, in New York, what is it that you see happening when those stakeholders are not at the table, and how are you going forward from there?

**Jasmine Budnella:** Yeah, sure, thank you. So, yeah, I just like to want to echo a couple of points that have been repeated over and over again, I think, throughout this whole entire panel is like the increase of criminalization has no impact on the overdose crisis. It, it will not reduce overdose deaths, it will not reduce fentanyl in our communities, it will not reduce... all it will increase is mass incarceration. And so currently in New York state, fentanyl really is in a lot of our drug supply so it's in meth, crack, cocaine, benzos. It's really in everything right now and overdoses are surging like I said before. You know Shantae, who was on the very first panel, talks a lot about like how it's been so hard to get people to call 911 in the event of an overdose and how much education and years of education it took to make people feel comfortable doing that.

And, and now there's a lot of fear. In New York City now, when you call 911, all overdoses are crime scenes right, so fatal or not. And so, as we look at like if we have our drug supply is toxic right now, and we have criminalization all over the place kind of like creeping in and then we have this federal ban that could potentially be permanent, it's really concerning about what that looks like on the ground. And it's very like, VOCAL also runs a syringe exchange program and I can tell you that, like a lot of our folks refuse to call 911, refuse to go to emergency rooms, after an overdose etc., because of the fear of the police state around drug use. And so the solution's really, right, if we're really looking at like, how do we turn the tide on the overdose crisis and save lives and start to deincarcerate folks and start to, like, take apart and dismantle the drug war, is it's absolutely about looking at what works. And we know that evidence has been around for a very long time on things that work and, as you all have said on this panel, the drug war doesn't. It does, it only works to do what it was designed to do, which was to lock up black and brown people, and poor people. And so medication assisted treatment, right, like works. If we can make sure that it's accessible, the barriers are removed, both of the federal and the state level, that we're meeting people everywhere we can, where they're at, you know, and ensuring that too is not being criminalized or police state-wise.

And so universal access to medication assisted treatment is really critical. I also think you know overdose prevention centers, also known as safer injecting facilities or safer consumption spaces, depending on where you're at in the country, absolutely will work to not only one, keep people alive right as overdoses and surging, but to connect people to care, as well as provide spaces and places where people can test their drugs, and also connect with people, care of like getting connected to housing services, etc., etc. I think you know if we're talking about fentanyl in general, and that, like we have fentanyl in a lot of our supply, we should be expanding access to drug checking as much as possible and expanding it in the community, expanding it harm reduction centers, expanding it as much as possible. I've been pushing really hard at the New York state city level to get fentanyl testing strips in vending machines across the city. That is a way that we can really talk about like hey if you're going to use, we need you to be safe, here is some naloxone, you know check your drugs and we're here if you need us. Right? These are solutions that are not rooted in like getting keep harming people, right, they're rooted in evidence, they're rooted in compassion and science that shows you know if we

combine a lot of these many of different tools to keep people alive, keep them safe, and keep them, you know, continue to offer them passion and dignity, then we can turn the tide. Right? But, like, if we continue down the road that has failed since its inception, it is just going to be more harm and more death. So, those are some of the solutions.

**Kanya Bennett:** Thank you so much for that, Jasmine. I think those are exactly the solutions that we need to be exploring. I want to be mindful of the time, I know we have just a few minutes left, so I want us to be very solutions oriented in in sort of what we offer now to the audience and sort of the charge that we want to provide with them. So, you know, Sakira, quickly, you know, do you have a reaction to what Jasmine is sharing? She has shared sort of what the public health approach looks like, looks like in New York. You know, how do we get the federal government to make those investments? And you know your response can talk about substance, but it can also talk about tactics. Just sort of who are will we need a table to get the investment that we need in health, as opposed to the DEA?

**Sakira Cook:** Well, first, I mean obviously, I agree with everything Jasmine said, and really commend VOCAL New York for the amazing work that they're doing on this issue and so happy that you know folks on the Hill are able to hear from this very local perspective, because I think it really will provide some color to what, for many of them is sort of a you know, an exercise in theory in many respects, unfortunately. It tends to be that way at the federal level is that people don't provide the practical experience of what actually is happening on the ground in the context of policymaking. So that's super important, and everything the Jasmine is talking about the federal government can play a role in. Right? They can incentivize these, this public health approach through their funding mechanisms and through the supports that they lend to states to tackle these crises. Instead, they are attempting to take the opposite approach, the approach that you know as Jason so notably you know said, with respect to making new mistakes, right, based on a failed war on drugs. That's what we are setting ourselves up to do. But we have an opportunity here, right? This this approach was the approach of the Trump Administration, unfortunately.

They were trying to take this different approach. We are in a new administration. We're in a ministry that has said they believe in abolishing all mandatory minimums. So, if you believe in abolishing all mandatory minimums, you should understand the connectivity between you know, a class wide scheduling of this type of drug that will necessarily implicate mandatory minimums, that will increase prosecutions, that will drive and incentivize prosecuting these types of drugs, as counter to your policy position around mandatory minimums. Like that that in and of itself is a contradiction. And so it is really imperative for this administration to think about this issue, as Jasmine has posited, as a pure public health crisis, as a way to educate not only policymakers about the approach, why we should take a public health approach, why what the DEA is saying is not actually accurate and incorrect and only a tool to incite more hysteria, to incite more criminalization, because that's it's job, the Drug Enforcement Agency, that's what it stands for. Right? That is their only job, so they are not thinking about this from a perspective of let's help people. No, their job is not to help. Their job is to put people behind bars. Their job is to continue to use the tools they've been given to fill the prisons. And so, we can't think that we're going to be able to charge an enforcement agency, like the DEA, with the, you know, unfettered you

know, you know power to be you know, addressing this crisis. Right? Because the only tools that they know how to use are the hammer.

The only tools that they know how to use are the sticks, right, prosecution. So, no we actually need to think about, which is why scheduling is a process that involves scientists at HHS, we actually need to be thinking about what is the pharmacological makeup? What will the impact of this drug be on someone's body? And then, once we understand that, how do we educate people? How do we steer people away from use? How do we remove stigma? Right? Jasmine talked a lot about stigma and the fact that people are afraid, because of the loom of enforcement, are afraid to take this approach. So, I charge, we charge, I think everyone on this panel would agree, that we are charging policymakers across the political spectrum to pull back the veil of the past and open their eyes to the present and the future. And this administration to really chart a new course, a course that is based in route in evidence, in science, and public health of everyone in the benefit of all. And that is what we need to be doing today. And that is what we're charging all of you who are watching this to go back to your members, to go back to your communities, and think through and to work with us to do. And so I'll turn it over to Patricia and Jason. Sorry, Kanya.

**Kanya Bennett:** Thanks, Sakira. No, we have we have just a minute. And Jason I saw you nodding your head, and so, you know, in a minute I am hoping that you can sort of agree with the charge that Sakira has laid out for us, and sort of what you're going to do to make sure that we have a, you know, diverse, bipartisan coalition moving us forward in this space. And then, you know, after you do that, in one minute, Patricia I want to make sure you take us home and really give us this call to action for lawmakers, for staffs, who are for wrestling with these issues.

**Jason Pye:** I'll say that the only thing, in my in my career in Washington, D.C., and I've been doing this now for a little bit over six years as a second career, the only the stuff that I felt the most the best about has been bipartisan work. It's the stuff that I've been able to talk about with friends and brag about at home, you know that's the that's the stuff I've felt good about. And whether it's passing the First Step Act or stopping war surveillance, protecting the fourth amendment. Those are the things that I want to continue to work on, so that means working with you, Kanya, it means working with Sakira. I mean it's working with anybody else. Whether they're right or left, I don't particularly give a damn what ideology, you have, as long as we're getting something good done. So that's the approach I've had, and that's the approach I'm going to continue have, as I work on the Hill under a new banner at the Due Process Institute.

**Kanya Bennett:** Thank you, Jason, we are excited to have you there. And Patricia, tell us how, as Jason said, we get this something done, how do we get it done?

**Patricia Richman:** Thank you, Kanya. What I would say to that is let's choose this moment to not repeat the mistakes of the past. When the need to do something overrides making sure that it's the right thing, the results are catastrophic. Now here Congress hit pause, despite the fear tactics of the Trump administration that were designed to pressure them to permanently adopt class wide scheduling and to double down on an enforcement first response, they had the fortitude to push back and extend it

temporarily by only a year. And they are asking them, we are asking two key questions that I think have been answered here today. Will class wide scheduling stop overdose deaths? Will class wide scheduling reduce the supply of harmful substances in our country? The answer is a resounding no. Today we have heard from the scientists. Class wide scheduling is a sledgehammer where scalpel would do. It is overbroad, it will criminalize harmful and helpful substances alike. Scientists are warning, just as they did 34 years ago when the Analogue Act was written, that blanket bans of substances hurt science, and may delay or eliminate the discovery of badly needed antidotes, treatments, and therapeutics. We should listen to them now, as we listened to them, then. When Congress wrote the Controlled Substance Act, it gave science and medicine an equal voice and direct control to prevent precisely this scenario.

Today, we heard from impacted people, from public defenders, from advocates, that even without class wide scheduling, prosecutors have aggressively brought war on drugs tactics to bear in fentanyl analogue prosecutions. We need to address that problem, not expand our authority. Because we've heard that communities will continue to be destroyed, children will continue to be separated from their parents, and our tax dollars will continue to fuel excessive punishment if we stay this course. Punishment will not deter, it will only fuel fear that will keep people from seeking help. And from public health experts today, you heard that overdose deaths have been, and will continue to rise. And even if there is a shift away from fentanyl analogues, it will be something more potent, more harmful. The cycle is going to continue, unabated. We cannot allow lies and disinformation from the Trump era to dictate today's policy. Science matters. Due process and liberty are not a mere inconvenience to sweep aside. We have to embrace science, evidence, and reason. Here, that means we have to let class wide scheduling expire. And it means, as representative Corey Bush said, at the hearing Jason mentioned last week, that we have to roll up our sleeves, and we have to do the work. We need to get into the community and start implementing evidence based, science first solutions that are proven to reduce demand, reduce overdose deaths, and that start to heal our communities and country. Thank you so much for this opportunity to speak to you today. Thank you all for gathering. This has been a terrific conversation.

**Kanya Bennett:** Thank you so much, Patricia.

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## CLOSING

**Douglas A. Berman,** Drug Enforcement and Policy Center

## TRANSCRIPT

**Douglas Berman:** So, I just want to close out the program by saying thank you to everybody. The speakers were just absolutely amazing and, as is often the case, even four hours is not enough time to cover all the dynamic issues that are here. I especially want to give thanks to Patricia Richman and Grant Smith for inviting all the panelists and an extra double thanks to Jana Hrdinova and Holly Griffin

for doing an extraordinary job keeping us all on time and putting all the infrastructure together, so you can hear from this incredible group of individuals, talking about this this real pressing issue. The Drug Enforcement of Policy Center was created a few years ago, in part because there just hasn't been a dedicated space in the academy, to talk about these issues on a consistent basis. And we are always eager to partner with any group, with any set of individuals, to elevate the discourse here. This conversation, the science and the advocacy perspectives, were so spectacular, and I would just be grateful for any other partnerships along these lines. It was terrific to work with all of you and I'm incredibly grateful that we can keep moving forward, putting science over fear, as our title suggested. So, so thank you all for spending the time today. As mentioned before the recording will be made available soon, and please feel free to reach out to any of us for any follow up. Thanks so much and have a great afternoon.