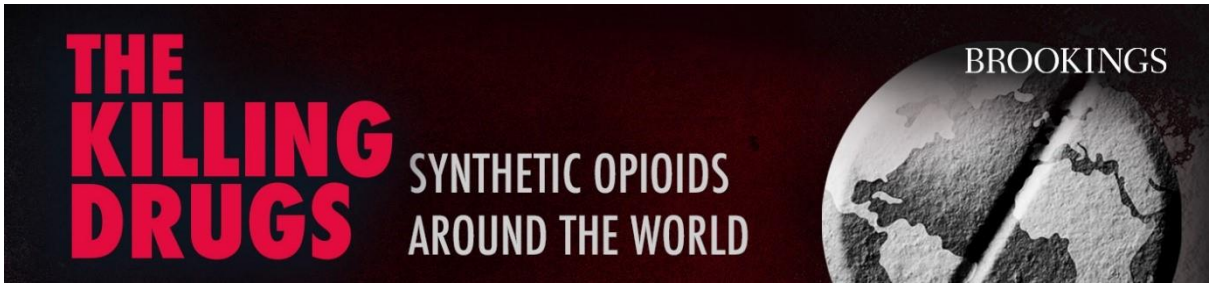

THE BROOKINGS INSTITUTION
***The Killing Drugs* podcast**

"The rising threat of synthetic opioids in Europe"

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Episode Summary:

In this episode, host Vanda Felbab-Brown speaks with Dr. Alex Stevens, criminology professor at the University of Sheffield, about the emerging threat of synthetic opioids in Europe, particularly fentanyl and nitazenes. Stevens argues that the greater availability of treatment access and harm reduction programs in Europe than in the United States could reduce the severity of a growing flow of synthetic opioids into Europe. Felbab-Brown and Stevens also discuss the challenges of controlling synthetic drug supply chains and various law enforcement actions taken in Europe as well as the role of Afghanistan's opium poppy ban.

[music]

FELBAB-BROWN: I am Vanda Felbab-Brown, a senior fellow at the Brookings Institution. And this is *The Killing Drugs*. With more than 100,000 Americans dying of drug overdoses each year, the fentanyl crisis in North America, already the most lethal drug epidemic ever in human history, remains one of the most significant and critical challenges we face as a nation.

In this podcast and its related project, I am collaborating with leading experts on this devastating public health and national security crisis to find policies that can save lives in the United States and around the world.

Starting with today's episode, we are looking beyond North America. We are exploring specifically the potential for the spread of fentanyl and other synthetic opioids into other parts of the world today in Europe. My guest is Doctor Alex Stevens, a professor of criminology at the University of Sheffield. His project paper is titled "Opioids in Europe: Preparing for a Third Wave."

Alex, thank you very much for joining me.

STEVENS: It's an absolute pleasure, Vanda. It such an important topic.

FELBAB-BROWN So, Alex, let's just start with the basic picture. What is the current experience of European countries with synthetic opioids, fentanyl, but also perhaps other types of synthetic opioids?

[1:28]

STEVENS: Well, there are synthetic opioids that are prescribed for the treatment of heroin addiction. So, methadone and buprenorphine, which are semi-synthetic and semi synthetic opioids are widely prescribed in Europe, more widely than in the U.S.A. for the treatment of addiction. And there are the deaths from those substances sometimes but at much, much lower levels than we've seen in North America and Canada and the U.S.A.

There's also some emerging and concerning signs of the availability of powerful synthetic opioids on the illicit market. Fentanyls for a few years, and in the last couple of years nitazenes. The numbers are still quite small. But there is concern that this might increase, especially if we see a reduction in the provision of heroin from the Afghan market.

FELBAB-BROWN: And, Alex, please explain to us what are nitazenes? How are they different from fentanyl-type drugs? Not in any great technical details, but just for our listeners, what is the difference between nitazenes and fentanyl?

[2:26]

STEVENS: Well, it's rather academic what the difference is chemically. It's what what matters is how they get into people. So, we've seen clusters of people overdosing in ways that we haven't seen before, you know, very quickly going over the top, going over, as we say in Europe, and being much more quickly affected and also affected in ways that are not so easily reversed by the use of naloxone.

So, we're seeing with nitazenes that people who might have come round after one shot of naloxone if it had been a heroin overdose, you know, they're coming round, but they might need more shots of naloxone. And also, because nitazene has a longer half-life than heroin does, they might come around with the naloxone shot, but then they might walk away from that. But then, because the naloxone comes out of the system while the nitazenes are still there, then they overdose again.

So, there's a lot of danger here for people who don't know they're taking nitazenes or fentanyls. Because unlike in the U.S. market where fentanyl has dominated the scene for a while now, people aren't seeking out fentanyl or nitazenes in European markets. We're just starting to see them basically as contaminants of what people think they're taking, heroin, but also, we're starting to see them in benzodiazepines as well. And given that in Europe there's quite a lot of poly substance use, people using heroin, benzodiazepines, and alcohol at the same time, that is really concerning for the rate of death that might occur.

FELBAB-BROWN: And this is also how, in fact, fentanyl emerged in the U.S. market where supply of fentanyl directly from China started coming in around 2013, 2014. And people were seeking opioids in general terms, often heroin, and encountered fentanyl without knowing it. And as you said, today fentanyl is pretty much mixed into just about every single drug. People often think they're buying cocaine. Although the U.S. cocaine market is small, they think they're buying—or smaller, I should say—they think they're buying methamphetamine, and then it will have fentanyl in it.

And so, just to explain, nitazenes, like fentanyl, are synthetic opioids. They are very, very powerful opioids. The basic chemical formula is different than in fentanyl. And unlike fentanyl there is no medical use for nitazenes, there is no known medical use for nitazenes right now.

So, in the latest report of the *European Drug Report* of 2024, the commission that prepares the report has warned that since 2019, at least 20 European countries have now detected a presence of some form of nitazene in their systems, in their countries. How concerned policymakers, law enforcement agencies, and the drug policy community in Europe about synthetic opioids, about nitazenes?

[5:19]

STEVENS: Well, some of us are very concerned already that we have an ongoing drug related death crisis related to opioids, but that has been more traditionally associated with heroin. So, in Scotland especially, and other parts of the UK, there is an ongoing drug-related death crisis to do with poly substance use of heroin, benzodiazepines, and alcohol. So, we've got this problem that's ongoing. And then you add nitazenes and fentanyls into the mix, it becomes even more concerning.

So, we've not yet seen the large numbers of deaths with synthetic opioids that we've seen on the other side of the Atlantic in North America. There's been these clusters reported in Ireland, in France, in the UK. We're seeing reports in the Baltic region. So, Estonia and Latvia have had tens and hundreds of people dying with these substances. So, the level we're at now it's not as big as it is in the U.S.A. But the worry is that it will get bigger. That's what we're concerned about. So, that's what we need to prepare for.

FELBAB-BROWN: And just give us a sense of perspective. You spoke about the ongoing heroin crisis and deaths related to heroin. How many people, how many thousands of people are we talking in UK or Europe more broadly?

[6:32]

STEVENS: So, in the UK it's over 4,500 people a year that are dying of drug related deaths, which we classify as deaths that are related to substances that are controlled under the Misuse of Drugs Act, where there's some evidence that that's to do with drug misuse, dependent use. And it's the UK that has the biggest problem in Europe. Across Europe we're seeing over 6,500 deaths each year, but it's more stable in continental Europe than it has been in the UK.

FELBAB-BROWN: And of course, Europe is experiencing a new drug as well, or new drug for Europe, not just synthetic opioids. But there's also the spread of methamphetamine in Europe, which traditionally was confined to some parts of Europe like the Czech Republic, and all of a sudden is being detected and linked to overdose as well in places like Spain, France, Portugal, Germany.

[7:20]

STEVENS: We're also seeing concerns about xylazines, which is not an opioid, it's more like a benzodiazepine and therefore doesn't respond to naloxone as well. And we've seen a cluster of deaths related to that substance. So, this, you know, this mixture in the market as the market becomes less stable and less predictable, that's what we're worried about.

FELBAB-BROWN: Yeah, absolutely. And there are different reasons why markets become unstable. There are potentially many external shocks, including that's the story of how fentanyl came to the United States. You know, one day Chinese suppliers realized there was this massive potential for supplying the U.S. opioid market with fentanyl. And today the big change is, of course, the expanding presence of Mexican cartels in Europe—Sinaloa cartel, cartel Jalisco Nueva Generación, certainly in the methamphetamine market. But these criminal groups have massive knowledge, experience with supplying fentanyl to North America.

Another possibility, of course, is that Chinese suppliers, Chinese trafficking networks will start bringing nitazenes on a much larger scale to their European counterparts, actors like the 'Ndrangheta in Italy, which is already starting to experiment with large scale supply of fentanyl—just in the experimentation stage but thinking about it according to what I'm told by Italian law enforcement officials.

[8:42]

STEVENS: But there a really interesting difference on the demand side in that these suppliers, these cartels bringing from China, from Mexico, who are bringing these substances to North America, were supplying into a market which was fertile because the rate of treatment coverage in the U.S.A. is so much lower than it is in Europe. So, there are several countries in Europe where 80% of the people who've got a problem with opioids are in medication assisted treatment.

FELBAB-BROWN: Can you list some of these countries?

STEVENS: Well, Germany, Austria, France. There's quite a few countries. The UK is not that high level. We're above the 40% threshold that's recommended by the World Health Organization.

And so, if you've got situation where you've got an older, unstable group of people using opioids, many or most of whom are already on medication assisted treatment, you're much less likely to have a market that is fertile for new entrants to bring more potent synthetic opioids into the system.

Now, it's still those people, you know, who are, you know, on the fringes of treatment, who might be using medication assisted treatment and other substances around that, who are vulnerable to dying with these substances. But much less so than in a situation where you've got large numbers of people using these substances who aren't in treatment and are unstably housed, living in places where they have no access to social services. That's not the situation in most European countries.

FELBAB-BROWN: Fascinating and very important difference. On another episode in this podcast series, we were speaking about treatment in the United States. And just one data point to highlight is that in the U.S., only 12% of people who are seeking treatment, which is not the entirety of users, are able to access treatment in fact.

Let me just stay a little bit with the supply side and law enforcement, and then we'll talk about these impressive harm reduction and treatment policies in Europe and how they are different and how they emerged in Europe. You mentioned, Alex, the possibility of a shock emerging out of Afghanistan. Afghanistan has been a principal producer of opium poppy and heroin for the past 20 years. It is the principal supplier of heroin to Europe. And of course, over the past two years the Taliban regime has had a ban on opium poppy. And there is certainly the possibility that eventually that ban on production will generate a drought in the retail market. Has that happened? What is happening with supply in Europe?

[11:12]

STEVENS: I'm getting conflicting messages. I was talking a couple of weeks ago to a group of people who are involved in street-based injection of heroin. They said they weren't finding any problems finding heroin. So, the Taliban's opium ban does not yet seem to be affecting the streets of the West Midlands of England yet. But other people are telling me that people are finding it harder to get good quality heroin. So, there might be something starting around a shortage of heroin from from Afghanistan.

Now, where there have been shortages before—the last Western European heroin drought was between 2010, 2012—what we saw in the UK in that at that time was a reduction in the number of heroin deaths as people found it harder to get it. But there was an increase in methadone deaths because people were seeking out diverted methadone to, you know, keep, keep, keep well in their own, their own terms.

Indeed, there was a previous shock in the early 2000s. And the responses to that were really interesting in that lots of different countries responded in very different ways. So, there's no linear relationship between, you know, a shortage of one drug and the the rise of another. There's a panoply of options out there for both users and suppliers to go to when they experience a shortage in one part of the system. So, for example, you know, the previous shortages of heroin in the Baltic region have been met by people transporting diverted buprenorphine from France, where it's widely prescribed, to fill that gap. Whereas other countries in the same region have, like Estonia, gone to fentanyls.

So, the problem for policymakers and law enforcement is it's very, very unpredictable what the response to the shortage that we think is likely to occur in the Afghan heroin market.

FELBAB-BROWN: And of course, there is also the possibility that the Taliban regime will not be able to maintain the opium ban. It was a struggle for them when they were last in power, of course. Then the regime was deposed by the U.S. intervention. That's not going to happen now. The regime has its own challenges. So, far, the leader of the Taliban, Mawlawi Hibatullah, has been very dogmatic and very willing to squeeze certainly the population already in starving condition. And we have seen, like, the first emergence of protests up in the Tajik north in places like Badakhshan that are not core constituencies for the Taliban. But yet to be seen how long can the Taliban maintain the ban and be causing devastating economic consequences.

[13:46]

STEVENS: And there's also the possibility of the balloon effect kicking in. The balloon effect was, I think, coined by a British diplomat who was deeply involved in the creation of the international drug control system back in the '20s and '30s, whereby if you press down on supply in one area, it pops up another. And that might well happen with the supply of raw opium going to Myanmar rather than Afghanistan, even if the Taliban were able to maintain the ban.

FELBAB-BROWN: And Myanmar opium poppy production is up, although it's mostly heading and supplying China right now, it's certainly well possible that it could start supplying Europe.

So, Alex, let's now turn to policies within Europe. You have been one of the prominent pioneers of expanded harm reduction approaches in Europe. Please explain to our listeners what does harm reduction mean, what does it do, and what can it accomplish in the case of synthetic opioids?

[14:38]

STEVENS: In its most narrow term, harm reduction is a fairly simple concept. That if things are going to happen and they're going to happen anyway, it might not be possible to stop them, but one can reduce the harm of that happening. So, an analogy would be driving a car and wearing a seatbelt. Driving a car is a risky operation, and that risk can be reduced by wearing a seatbelt. Taking heroin is a

risky operation and if people are not able to stop, there are still ways you can reduce the harms of doing it.

This was an approach that was brought up in Europe from people who were using drugs who are at risk of catching hepatitis originally in Rotterdam and then catching HIV from sharing needles in Merseyside, Liverpool. And those are the two sort of founding places of the harm reduction approach in the 1980s and ‘90s, where governments realized that they were facing an HIV epidemic. People were going to continue using heroin, and if they didn’t do something about it, that that those infections would spread.

So, the harm reduction approach was started off by, for example, providing hygienic equipment—needles, syringes, spoons, to take the heroin, so that people wouldn’t be transferring infections between them. So, the needle and syringe program is the iconic harm reduction intervention.

But since then, there’s a lot more been developed by way of harm reduction. So, for example, another way of of reducing the harms of drug use is by checking the contents. And across Europe, there are many cities now which have drug checking services. In Wales there’s a postal service. People can send in samples of the substances they’re considering taking. And the results of the forensic analysis of those drugs will be posted online for them to see. Other examples of harm reduction services include overdose prevention centers. So, places where people who are going to use drugs can go and do so in a more safe environment, so that if they do overdose they can receive oxygen, naloxone if they need it, and they don’t die.

So, the basic principle is that people have a right to life, whether they use drugs or not. And harm reduction services protect that right to life.

FELBAB-BROWN: And as you mentioned in your opening remarks, access to treatment and access to harm reduction is much more widespread in Europe than in the United States, where for a long time it was taboo, often with the justification that if people do not find it so risky to use drugs, more people will be using drugs, they will be not deterred anymore, they won’t be scared, and there will be much greater proclivity towards using drugs.

And it really took the Biden administration to bring even the term “harm reduction” to the official approach of the U.S. counternarcotics policy. In fact, it was one of our colleagues in the project, Regina LaBelle, whom our listeners had a chance to hear on another episode, who as an acting head of the U.S. Office on Drug Control Policy, brought the word harm reduction front and center into the strategy. And, in 2024, in the spring of 2024, U.S. Secretary of State Blinken used the term harm reduction at the Vienna meeting of the drug convention, which was, again, unprecedented for a U.S. official to do.

That, said, the extent of availability is still very, very far from what is present in Europe. Why is that? Why, in your view, have European countries been so much more willing to adopt policies such as harm reduction, access to treatment, than the United States? What explains the politics of those different decision choices?

[18:15]

STEVENS: These are decisions that are made on the basis of morality rather than evidence. I've just written a book called *Drug Policy Constellations*, which is about the role of power and morality in the making of drug policy in the UK, and even between different jurisdictions within the UK—so, between England and Scotland. One can trace the differences that different moral backgrounds, different ethico-political bases have on which country will adopt which type of policy. So, for example, Scotland has gone much further with harm reduction than England has, partly because the government and the culture are more accepting of the idea of harm reduction.

And we've seen a lot of resistance in the U.S., as you mentioned, to the idea of doing harm reduction. The idea, for example, that harm reduction enables drug use—that's not an evidence-based idea. That's a purely moralistic judgment as to whether one wants to see people using drugs or not. And so, if one has a culture where there is a moral stigmatization of drug use, one is much less likely to adopt evidence-informed measures like harm reduction.

So, we've seen a divide between drug policies in Europe and the U.S.A. going back to the 1910s. You know, there was a decision of the Supreme Court in 1990 in the U.S. that it wouldn't be acceptable to prescribe heroin to people who'd become dependent on it. That was the opposite decision that was taken in the UK in the 1920s, which was to prescribe heroin to people who'd become dependent on it.

So, we have a bigger cultural acceptance in Europe of the idea that let's just do what's effective without doing the moral judgment. I'm not saying there's no moral judgment in the UK or that or that the European policies are perfect, but there are fewer moralistic obstacles to doing effective work with people who use drugs in Europe than in the U.S.A.

FELBAB-BROWN: So, you know, in the U.S. we are just moving toward methadone maintenance. You have places where methadone maintenance is available. That was controversial enough, and it took a lot of changes. And in fact, it took the horrific deaths that we are seeing with fentanyl to move towards something like that. Whereas people have also been dying in the U.S. from heroin before the fentanyl class of drugs emerged, and methadone maintenance was prohibited. But heroin maintenance is still very much taboo. What countries in Europe do have heroin maintenance and what is the evidence from those markets?

[20:38]

STEVENS: Well, there are several countries. It used to be known as the British System. Until the 1960s, it was common practice for general physicians in England and the rest of UK to be able to prescribe heroin to their patients who had become dependent on it. That was abandoned in the '60s and '70s, and people were mostly moved into methadone clinics.

It was reinvented in Switzerland in the 1980s and '90s, largely, through the work of Professor Doctor Ambrose Uchtenhagen—the late, great professor doctor—and colleagues of his who reinvented heroin assisted treatment as a second line

treatment for people for whom methadone and buprenorphine didn't work. For those people, heroin has proved to be very effective in reducing the use of street heroin and reducing the offending that people are involved in to fund their, their habits.

And so, from Switzerland, it's spread back to the UK. There is currently a heroin-assisted treatment clinic in Glasgow and in the West Midlands. And there are several other countries in Europe that also provide heroin-assisted treatment clinics.

FELBAB-BROWN: Let's turn a little bit to law enforcement and specifically whether there is a possibility that law enforcement could, by focused attention, specifically focusing on synthetic drugs, on nitazenes or fentanyl, could stop of the supply. Is that a good idea? What in your view is the range of effectiveness that it can achieve?

[22:05]

STEVENS: Well, this is a good idea in theory. And so, there's a concept called harm reduction policing, which has been adopted at various times by the British police. The Serious Organized Crime Agency, which coordinates the efforts to to enforce laws against drugs, used to call itself a harm reduction agency. In doing so, it took up the idea that it's not about the amount you seize or the number of people you put behind bars. It's about what are your law enforcement activities actually achieving in reducing the harms of that market to the population you're serving? And the best way to reduce the future possible harms from potent synthetic opioids might be to keep those drugs out of the supply.

So, one would therefore want to focus one's efforts on those traffickers who are going to be bringing in fentanyl and nitazenes into the market.

The problem is, we don't know who those people are. We find it extremely difficult to detect these substances because they're so small. They're so potent at such small amounts that it's really, really difficult to keep a track on their presence in dead bodies, let alone in customs operations where people are dealing with millions of packages every day.

So, yes, in theory, it would be a good idea to focus law enforcement efforts on ensuring that the most harmful types of supply are the ones that get the most attention and the most efforts to prevent those markets developing. It's just really difficult to do.

FELBAB-BROWN: There are some positive examples. You know, you spoke about how various European countries reacted differently to the 2000, 2001 shock of heroin coming from Afghanistan being turned off. On the one hand, we had the emergence of fentanyl market in Estonia. But several years later, we also saw the spread of fentanyl to the Nordic countries. And law enforcement at the time was able to just starve off the market, jumping aggressively on fentanyls coming into Norway, to Sweden, and essentially turn off the supply and deter dealers from bringing it in by very strong, punishments.

Now, that is more feasible if the supply is more limited and if there are fewer wholesale suppliers, fewer dealers bringing it in. In today's world where there is so much experience the drug trafficking organizations have with fentanyl from North

America, not just the United States but Canada and Mexico—the cat's out of the bag. And of the very super potent criminal groups—Sinaloa cartel, cartel Jalisco Nueva Generación—they are spreading in Europe, establishing alliances, can easily become vectors of that spread of fentanyl, nitazenes, that will not be so easy to turn to off, will not result in the same success that the Nordic countries could achieve a decade, a decade-and-a-half ago.

Can you give us a little bit of a sense of the crime market in Britain? You spoke about the fact that we often don't know who these people are. What is known about wholesale supply or retail in Britain, for example?

[25:12]

STEVENS: In terms of what is known about the supply of these types of substances into the European and UK markets, it's really difficult to tell because the law enforcement agencies play their cards very close to their chest until they have successes in their own eyes, like the EncroChat takedown, which is still being talked about in Europol circles as a massive success, you know. So, there was, you know, this ring of encrypted communications through web services known as EncroChat. The European law enforcement agencies were able to get into that behind the protection and took out hundreds of dealers.

The problem is we don't know whether that had any effect. You know, Europol has not released any analysis of whether taking out all those dealers and seizing all those drugs actually had any effect in reducing the availability, increasing the price, or reducing the harms of these substances.

And there's this general vacuum in policymakers' knowledge of what the effects of law enforcement activities are. There's an academic vacuum. If you try and do a systematic review of knowledge on what the effects of seizing drugs or arresting dealers is, you find very little evidence. And the evidence there is is not highly encouraging.

So, the problem that policymakers have, therefore, is that they are fishing in the dark for the effective methods by which to enforce laws, to try and nip off these problems before they they can occur.

And to be honest, the law enforcement agencies don't really help themselves by keeping their hands so close to their chest. At _____ we would love to help that effort of reducing the harms. We would like to use, for example, the information that law enforcement agencies hold on the seizures they have, the types of substances that they're seizing, the types of people they're seizing them from. And we would then be able to work in partnership with them to work out what are the effective ways by which to prevent the most damaging ways that drugs are being brought in, and the most damaging paths and patterns of drug trafficking.

We're not invited into those circles. And so, it becomes very difficult to either know what's going on or to create knowledge on how to reduce the harms of what's going on.

FELBAB-BROWN: Well, and in the opening episode of *The Killing Drugs*, we heard from our colleagues on the project about the paucity of data in the United States and how even data that the U.S. Drug Enforcement Administration used to release about a decade ago has now dried up, compounding the problem of fishing in the dark. But despite the fact that there is much less information about the law enforcement side and incomplete information about the drug markets in general, including on what's happening on the retail side, conflicting information about which you spoke, Alex.

[28:10]

STEVENS: I would also like to make the point that this is also a product of the moralistic attitudes towards drug use and drug policy. So, one of the reasons we have lots and lots of evidence about the effectiveness of things like needle and syringe programs and heroin assisted treatment is because there're rarely been allowed to happen without there being a rigorous evaluation of of multiple pilot studies. That is not the case with law enforcement activities.

For example, we often hear calls for increasing the punishment, the prison sentences for people who traffic drugs. But that's never been shown to work in a randomized controlled trial. Nobody requires there to be that burden of proof on people who want to invest money in law enforcement activities. These these things get done because they're in line with most people's moral expectations about what the right thing to do is, not because there's any evidence that they reduce drug related harms.

FELBAB-BROWN: Well, and as I explore with our producer Fred Dews on the Mexico episode, we also see the current experiment of the outgoing Mexican administration of Andrés Manuel Lopez Obrador of just completely giving up on law enforcement and giving the Mexican criminal groups a carte blanche that has neither reduced violence nor reduced any harms. In fact, allowed the Mexican criminal groups to be just taking over every legal and illegal economy in the country and keeping violence at the very high levels.

[29:32]

STEVENS: I think it's worth noting that in Europe we're starting from a much, much lower level of violence in the market. And so, when violent incidents do occur—there was an outbreak in, in the Netherlands in the last few years, and we're still talking about handfuls of people, you know, suffering, you know, horrible things happening to them.

FELBAB-BROWN: And for that matter, it's the same difference in the United States, although the very same Mexican cartels, Sinaloa and Jalisco, are the principal suppliers of all drugs to the United States, certainly cocaine, heroin, fentanyl, and methamphetamine. They act in the U.S. very nonviolently, whereas they act with extraordinary violence and have the capacity to take over legal economies in the country in a way that's prevented by law enforcement in the United States.

STEVENS: Well, in Europe, the state is much more present, and guns are more tightly controlled.

FELBAB-BROWN: Right. Well, and in the Mexican case, the last administration just completely gave up on all law enforcement. This is a big policy experiment of just not having any law enforcement toward violent criminal groups.

Alex, even though we are fishing in the dark because of the paucity of data, let me ask you the final question as a policy recommendation question. Given that the synthetic opioid epidemic has not yet hit Europe, or at least not yet anywhere on the scale that we see in Canada, in the United States, and that we are also seeing in Mexico, what can Europe do now to prevent it or reduce its scale?

[31:01]

STEVENS: Yeah. So, the chapter I've written for the Brookings Institution report on this issue is called "Preparing for a Third Wave." So, the first wave of opioids in Europe was the heroin that increased in use in the '80s and '90s. The second wave was that being met by large numbers of people being recruited into treatment services, largely to do with medication-assisted treatment using methadone and buprenorphine. We're now on the possible cusp of a third wave.

But I think we should learn from the success of dealing with the first wave. We need to get more people into treatment—that reduces the drug-related death rate. And we need to invest in harm reduction services that we know will keep people away from the most dangerous patterns of use. And even if they get involved in those most dangerous patterns of use, reduce the likelihood that they will die.

So, we therefore need to expand opioid agonist therapy. We just get more people into it. We need to diversify the types of medication-assisted treatment we're using. So, methadone, buprenorphine, and heroin-assisted treatment. And in those places where we're most likely to see people dying from synthetic opioids, which are the most deprived cities in the UK, Ireland, some other some other places, we need to invest in overdose prevention centers. Now they're widely available in places like Switzerland, the Netherlands, Germany, but not so much in the UK or in some other places like Ireland where people are vulnerable.

We also have harm reduction services that, like drug checking, that could also be very effective in informing people about what's in the market. So, both policymakers can respond to it but also users can make decisions about what risks they're going to take when they know what's out there for them. So, there's a range of things that we could do to reduce the risk of this third wave of opioid deaths in Europe.

FELBAB-BROWN: And I would add, continuing with the law enforcement effort to turn off the spigot before it gets going, because once the toothpaste is out of the tube—as another colleague of ours, Jon Caulkins, said on his episode—it's very difficult for law enforcement then to be able to reverse those patterns. So, the more that can happen beforehand the better, along with all the harm reduction and treatment access that you were speaking about.

[music]

Alex, thank you very much for being with us today and sharing your important insights.

STEVENS: Thank you.

FELBAB-BROWN: *The Killing Drugs* is a production of the Brookings Podcast Network. Many thanks to all my guests for sharing their time and expertise on this podcast and in this project.

Also, thanks to the team at Brookings who makes this podcast possible, including Kuwilileni Hauwanga, supervising producer; Fred Dews, producer; Gastón Reboredo, audio engineer; Daniel Morales, video editor; and Diana Paz Garcia, senior research assistant in the Strobe Talbott Center for Security, Strategy, and Technology; Natalie Britton, director of operations for the Talbott Center; and the promotions teams in the Office of Communications and the Foreign Policy program at Brookings. Katie Merris designed the compelling logo.

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I am Vanda Felbab-Brown. Thank you for listening.