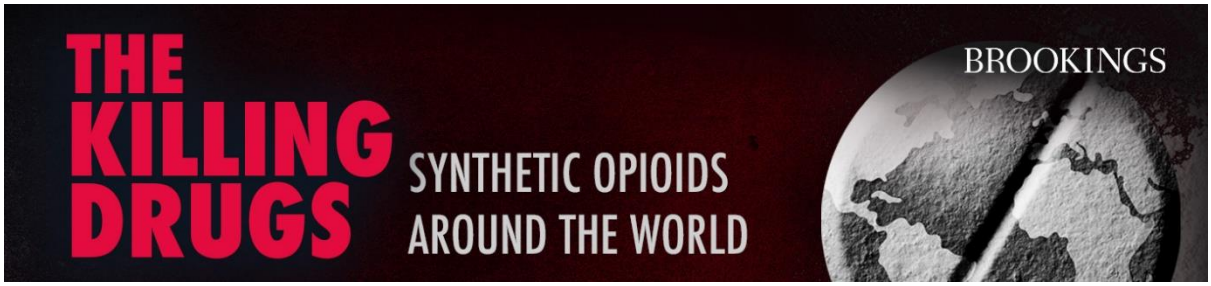

The Brookings Institution

The Killing Drugs podcast

"The radical challenge synthetic opioids pose for drug policy"

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Guest:

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Episode Summary:

In the show's first episode, host Vanda Felbab-Brown speaks with Dr. Jonathan Caulkins, a professor at Carnegie Mellon University, about the unique challenges that synthetic drugs, and particularly synthetic opioids, pose for policy. After laying out the history of drug use in the United States and the origins of the fentanyl epidemic, they discuss the pros and cons of a wide range of policies—from various law enforcement approaches to prevention, treatment, harm reduction, and prescribed safer supply.

[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.

On today's episode, we are exploring a wide range of policy responses to the synthetic drugs crisis. My guest is Doctor Jonathan Caulkins, H. Guyford Stever University Professor of Operations Research and Public Policy at the Carnegie Mellon University Heinz College, and a member of the National Academy of Engineering. His project paper is titled "How should policy respond to surging supplies of dangerous drugs? With more supply control, less supply control, or by prescribing safer supply?"

Jon, thank you for joining me.

CAULKINS: It's an honor to be part of the project.

FELBAB-BROWN: Jon, several years ago, you, Keith Humphreys, who is also another colleague of ours on this project—the Fentanyl Epidemic in North America and the Global Reach of Synthetic Opioids—and I wrote several articles arguing that the spread of synthetic drugs, especially synthetic opioids, is a radical challenge to drug policy and that it is even reshaping foreign policies of countries such as the United States, which for a long time has been the core architect of the global drug policy regime and its implementation. Why are synthetic drugs such as fentanyl and other synthetic opioids so different from plant-based drugs such as cocaine and heroin?

[2:08]

CAULKINS: Synthetic drugs expand supply for three important reasons. The first is they're just way less expensive to produce. Take fentanyl compared to old fashioned heroin. It is literally less expensive per kilogram, and it packs far more doses per kilogram. So, it's just much cheaper.

But it goes beyond that. It's also freeing production to be able to happen essentially any place on Earth. To grow crop-based drugs, you have to have either criminal control of an area where the peasants farm or a complete lack of state control. There are plenty of places around the world that have that condition, but it's not everywhere. Synthetic drugs, by contrast, can really be produced essentially anywhere. We talk about labs, but these labs are not big. They're not sophisticated. They're not capital intensive.

And then the last thing is production is fast. If law enforcement manages to seize a surprisingly large amount of crop-based drugs, it takes a growing cycle to replace

what has been lost to the supply chain. With synthetic drugs, it can be 24 hours or 48 hours to replace what is seized.

So, it's a radical technological change that effectively expands supply from the perspective of the criminal networks.

FELBAB-BROWN: So, the only element that might be a challenge for a producer of synthetic drugs to get are precursor chemical is. Is that the case?

[3:47]

CAULKINS: In theory, absolutely. They are dependent on precursor chemicals. The problem is precursor chemicals are also pretty easy to make. The one ace in the hole for supply control with respect to precursor chemicals is they're so crazy cheap that there's not a very large number of large suppliers of them. So, there's a bit of concentration in that segment of the supply chain, which makes it potentially more vulnerable to be shocked.

Whereas by contrast, there are hundreds of thousands of peasants. If you eliminate a thousand or ten-thousand peasants, you're not disrupting the supply of the crop. The precursor controls come from a smaller number of actors. So, in theory, if you surprise them, you could shock the supply chain. But the precursor chemicals are not themselves extraordinarily difficult to produce or to source.

FELBAB-BROWN: And the principal sources of precursor chemicals for fentanyl, for methamphetamine, are China and India, as we will explore in later episodes of the podcast.

So, Jon, in your paper, you lay out the pros and cons of a wide range of policy approaches to responding to the fentanyl challenge. From intensified law enforcement efforts to increase legal supply. You unpack the key assumptions and presumed outcomes of each of these approaches. Let's start with looking at law enforcement policies. What can law enforcement do? What are the limitations of law enforcement efforts? And what should they focus on?

[5:26]

CAULKINS: Sure. I'd like to set the stage by making two distinctions. One is the difference between drug law enforcement and supply control. Sometimes people mistakenly think they're the same thing. But supply control is just what it sounds like. It's trying to constrain the supply, drive up the purity, adjusted price, reduce availability, and so on. And one of the functions of drug law enforcement is to constrain supply. But there are other ways of constraining supply, such as trying to control precursor chemicals.

And just as drug law enforcement is not the only way to constrain supply, constraining supply is very much not the only function of drug law enforcement. The other very important role of drug law enforcement is to control all of the public safety threats of the market, not shrinking the market or shrinking supply, but controlling the collateral consequences, or the negative externalities. To be concrete, violence and corruption and disorder.

So, drug law enforcement can contribute to society being better off if it halves the amount of drug-related violence, even if the amount of drugs flowing through doesn't change. That's the first important distinction between drug law enforcement and supply control.

[6:43]

Then the second is a subtle point. But illegal markets tend to exist in stable equilibria that are small or large. To be less formal, this is a little bit like toothpaste out of the tube problem. When the markets are very small, that can be a stable situation and a highly desirable situation, because if the markets are small, you don't have a lot of use and you also don't have a lot of market-related harm.

Once the markets have tipped to the high-volume equilibrium, it can be very difficult to tip them back to a low-volume equilibrium. Not impossible. For instance, in the 1980s we had flagrant street markets for crack that was in effect a high-volume equilibrium. And through great effort, as well as technological changes that removed the need for place-based retailing, we were able for a time anyhow, to push those markets back to operating in a quieter mode.

FELBAB-BROWN: Let me jump in here. I want to highlight, to emphasize what you just have said, that one can have significant use and not very significant problems associated with that use.

CAULKINS: Let's be even more precise. You can have a lot of use, but not a lot of problems associated with the market. So, some markets that supply many metric tons generate enormous violence. Some markets that supply many metric tons have much lower levels of violence.

FELBAB-BROWN: And the classic distinction here is East Asia, which is an enormous producer of drugs, which is also an enormous consumer of drugs, but has homicide levels in the very low per 100,000, as opposed to Latin America, which has very significant consumption of illicit drugs, significantly growing consumption, very large production, and has violence levels in the tens per 100,000.

[8:43]

CAULKINS: Absolutely. Now, with that sort of preamble, we're set to answer your very good question, which is what has law enforcement, drug law enforcement done for us? Drug law enforcement for decades delivered a phenomenal success of keeping drug markets at a low-volume equilibrium.

For instance, fentanyl was invented many, many decades before it emerged in a large way in North America, circa 2014. Likewise, take heroin. In the immediate post-World War II era, heroin was confined essentially to just New York City. Then, in the late '60s and early '70s, there was the first heroin epidemic. And it spread, but it spread basically to other major cities and even more specifically, primarily disadvantaged neighborhoods within those large cities.

The opioid problem post-2005 was much more a problem throughout the country. And you can say, oh, that's a disaster, things got much worse. But you can also say,

wow, for decades, that market was essentially nonexistent in small towns and rural areas.

So, drug law enforcement has succeeded in protecting big chunks of the country for decades from high supply, the kind of thing that troubles us now.

FELBAB-BROWN: And I would also say from some forms of violence. So, if you look at who the principal suppliers are in the U.S., they are the Mexican cartels. They behave very differently here than in Mexico.

[10:17]

CAULKINS: That's the second point I was going to get to. So, drug enforcement has delivered two things to us. First is it kept the markets in a low-volume equilibrium for a long time. The second thing is, even now that the markets are more at a high-volume equilibrium, we still have inside U.S. borders far less market-related violence and extremely less market-related corruption and threats to our democratic institutions. It's really very rare in the United States for drug traffickers to assassinate journalists. That happens elsewhere.

And that's not just luck. That is a consequence of hard work and the integrity of our institutions. It's something to celebrate. It's something to protect, to not take for granted. And it's something we can try to expand even beyond the successes that we have so far.

FELBAB-BROWN: Absolutely. I very strongly endorse that. Now, let me just ask you one other question about law enforcement. There is, of course, tremendous amount of criticism of drug-related law enforcement, a lot of which focuses on either the problems that it generates abroad or specifically efforts to constrain supply abroad has generated often very negative side effects for many countries. But in the United States, it also has led to, bad policies such as vast criminalization and imprisonment of users for a long time that fortunately the United States has gone away from.

But now there are suggestions that perhaps the unique feature of fentanyl is that often dealers, wholesale suppliers, mix it into other drugs without users knowing that they are, in fact, getting a drug that also contains fentanyl, a source of overdose. So, people are suggesting, well, maybe law enforcement in the United States should predominantly focus on fentanyl markets or maybe specific fentanyl targets. What's your thought on that?

[12:17]

CAULKINS: So, we can unpack what has gone wrong with drug law enforcement in the past. And one of the things that has gone wrong is when it is exerted enormous resources trying to put toothpaste back into the tube. And one possibility is that targeting fentanyl in particular is a futile effort to put toothpaste back in the tube. We don't know for sure. Maybe it's possible to put that toothpaste back in the tube. And if we ever could, that would be a gigantic win.

So, I don't begrudge the people who are optimistic and hope that focusing law enforcement specifically on fentanyl, essentially trying to put fentanyl sellers at a

competitive disadvantage relative to heroin sellers and so tip the market back towards heroin. I understand why people have that aspiration. I personally am pessimistic that that will turn out to be possible, but I would be thrilled to be proved wrong.

FELBAB-BROWN: So, let's now look at other policy interventions and the broad category of what people refer to as treatment or harm reduction, which are two distinct approaches. And in fact, on further episodes in this podcast series, we will be hearing specifically about harm reduction and specifically about treatment as also our papers in the project explore.

But let's just get a broad take from you. What would be the effects of predominantly giving up on law enforcement and focusing predominantly or solely on treatment and harm reduction?

[13:54]

CAULKINS: Well, I think it's a problem in at least two respects. The first is giving up on drug law enforcement, when what you really meant was giving up on supply control, is a category error. We don't want to give up on or stop valuing law enforcement's capacity to mitigate some of the violence, corruption, and disorder of the markets even if we no longer think that drug law enforcement would be able to tip the markets back to a low-value equilibrium. So, that's first error.

The second issue is that let's take treatment for instance. First of all, medication assisted treatment is really mostly only available for opioids. Now that is the biggest problem in the United States. But we sometimes forget that our treatment technology for stimulants like methamphetamine and cocaine is not in the same league as our treatment technology for opioids.

But, even in the space of opioids, the challenge with treatment is it works, and it doesn't work in the following sense. Treatment one hundred percent works in the sense that it makes lives better. It saves lives. It's a cost-effective way to use taxpayer dollars. We should expand it to the greatest extent possible. But it is not a cure. It is not a fix.

My favorite metaphor for explaining this is to contrast broken arms and blindness. If I break my arm, the American health care system can essentially fix it in about six weeks, and my arm is basically good as new. If I become blind, in most cases the best medical technology cannot restore my sight. There are things we can do in response to blindness, and we should do them. We should provide me with a tax break and a seeing eye dog and other forms of assistance. That is compassionate, that is sensible, but it doesn't restore vision. Treatment for substance use disorder on the spectrum between broken bones and blindness is closer to blindness than sometimes we are willing to acknowledge.

FELBAB-BROWN: But of course, enabling people to live as normal lives, destigmatizing their chronic illness, helping them maintain jobs, helping them maintain families, makes tremendous sense from both the compassionate element that you were speaking about as well as from protecting communities as much as possible.

[16:27]

CAULKINS: Oh, a hundred percent. We should do it. But we should just be realistic also that if there are a thousand people struggling with opioid use disorder and we roll out the best treatment we know how to do, we are not going to get a thousand people who are employed, in intact marriages, living happy lives 12 months later. The technology that we have available to us is not one that solves the problem on its own.

I think it was *New England Journal of Medicine* just this week, study came out of the HEAL intervention where, roughly speaking, we rolled out everything we know how to do in 34 communities. And then, with a delay to 33 that were the control group for the 34 that received the intervention right away. And the net result was a 10% reduction in overdose death, which was not even large enough to be statistically significant.

FELBAB-BROWN: And explain what went into the intervention. So, that was providing methadone, providing buprenorphine. What were the policy elements?

CAULKINS: Also, naloxone. It was sort of the whole suite of evidence- based interventions that we have.

Now the defenders of those policies would say, oh, COVID happened in the middle of that. And that is true. But I also think we can't back away from the fact that when we threw everything we knew at those communities, we did not solve the problem. So, relying entirely on treatment and harm reduction is just not a solution. In the long run, the solution is eliminating the inflow to opioid use disorder.

FELBAB-BROWN: How could that happen? Can it happen? You know, many critics of the of existing drug policies, which they often inappropriately label the "war on drugs," there is a lot more existing policy than just war on drugs, will say, look, this doesn't make any sense, we should just legalize drugs. So, how can we eliminate the flow of people to the use in the first place?

[18:35]

CAULKINS: We had a flow into opioid use disorder up through about 2000 that was a small fraction of what we had as a result of liberal prescribing of powerful prescription opioids for chronic conditions in people who were not terminal. So, always we thought that powerful opioids were appropriate for cancer pain and people who are terminal. The big change in the late 1990s was to make them available to people suffering chronic pain who were not at the end of their lives.

FELBAB-BROWN: And with a false claimed that these powerful opioids like OxyContin are not addictive.

CAULKINS: Correct. So, the usual statistical lie was to say only blank percent of people who receive an opioid prescription developed dependance where the denominator included short-term prescriptions, like you wrench your knee, and you get prescribed opioids for five days. When the denominator is just long-term

prescribing of opioids, the capture rate to dependance is very troubling. High enough that we now understand that that was a categorical error.

[19:49]

Okay, so you asked about legalization. Legalization on a commercial model is going to result in much larger rates of consumption. Take cannabis, for example. The price per milligram of THC has fallen by 90%. The number of people who report using daily or near daily has grown twenty-fold from 1992 to 2022. For cannabis, you can either say that's a moderate public health problem, or you can shrug your shoulders and say, who cares? But any kind of massive expansion in daily and near daily use of powerful drugs like fentanyl or crack or meth is a public health disaster. Commercial legalization is a terrible idea for powerful drugs.

The serious suggestion, which may or may not be a good idea but at least is one that should be discussed, is prescribe safer supply that Canada, in particular British Columbia, are pursuing.

FELBAB-BROWN: And so, please explain to us, Jon, what is the difference between just legalizing drugs like heroin, cocaine, fentanyl and what is prescribed safer supply?

[20:59]

CAULKINS: It's a great question. So, the concept with prescribed safer supply is for people who are already suffering from opioid use disorder, if we discuss opioids. The concept for prescribed safer supply is available for all drugs as a practical matter, the vast majority of participants in the programs in Canada are for opioids. So, to keep things simple, I'll stay with opioids.

So, the concept is people who have already developed opioid use disorder would simply be given their drug of choice or an equivalent drug in hopes that they would use that instead of the illegal opioids. The benefit is that the pharmaceutically produced prescribed safer supply are known doses. Every pill would have exactly the dose that it's legal to have. Whereas the illegal supply, often called toxic, has high variability from bag to bag, and when you get a surprisingly high dose in the bag, you can end up overdosing.

FELBAB-BROWN: And you can have of a lot of other stuff mixed into it, such as xylazine. Whereas with the safe prescribed supply you would be getting exactly what you know you're getting.

CAULKINS: Correct. So, that's the concept. That's the hope. And almost certainly you would expect prescribed safer supply to help the participants in the program, even if they sold the prescribed safer supply into the illegal market, you're at least making it richer. People who have more money are going to have better health outcomes.

[22:25]

But the catch or the challenge of prescribed safer supply comes in a couple of market facts. One is that prescription opioids sell for a premium in illegal market. I

should back up. There are illegal markets for prescription drugs. So, there's illegal markets for fentanyl. There's also illegal markets for prescription drugs. And the price per morphine milligram equivalent for the prescription drugs is about triple.

So, the catch is that if you give high quality prescription drugs to somebody who is in the desperate throes of opioid use disorder, one of the things that's available to them is the option of selling the prescription drugs you give them, and then using the money from that to buy illegal opioids and triple the number of morphine milligram equivalents that they have.

FELBAB-BROWN: And this is, in fact, what happened a decade, decade and a half ago with Oxycontin. Many people who became dependent would be getting Oxycontin from the doctors and selling it and buying other stuff.

[23:29]

CAULKINS: Yes. I mean, in fact, with the prescription opioid problem that we had in the past, it was sort of more often that, I mean, it happened some, but a lot of times they were being cut off from the prescription opioid supply. And it was around that time that they traded down to the cheaper illegal opioids.

So, with prescribed safer supply, one of the challenges is you're trying to give this sort of premium type of opioid to people, some of whom just plain want lots of morphine milligram equivalents, so they have an incentive to sell it away. And it is possible to sell it away. And it's possible for the illegal market to aggregate the pills that they're selling and then supply those pills to people who do not yet have opioid use disorder. That's the big concern.

And the second challenge is the scale because of tolerance. The typical person in Vancouver today using two point bags of "downs," their slang for the illegal opioids, is consuming something like 2,400 morphine milligram equivalents per day. And when you're working with somebody who does not yet have opioid use disorder, even a 100 morphine milligram equivalents per day is a dose that we are concerned about in terms of the ability of that to trigger the development of opioid use disorder.

So, the second market reality that's a challenge, besides the 3 to 1 price premium, is that the sheer volume of opioids and morphine milligram equivalents you need to sort of maintain the person who is the active user in illegal markets with opioid use disorder, is a very large, and very large compared to what it takes a naive person to develop opioid use disorder in the first place.

So, it is a real possibility, it's a real concern that diversion from prescribed safer supply could end up sort of perpetuating the problem. You're trying to help the person who's already got opioid use disorder. But in the process of doing that, you might be creating the conditions that create new inflow of people into the situation that is what is motivating you to do the intervention in the first place. Chasing your tail in effect.

FELBAB-BROWN: So, you know, potentially there is a solution to reduce the risk of diversion and perhaps even eliminate it. And this would be that the safe prescribed dosage is only given to people inside a clinic. Or perhaps, but which of course

generates barriers to access. So, people might find it too expensive to travel to the clinic, especially if they need to be using frequently, daily or multiple times a day.

But potentially they could also be instructed to use on camera. Now it's hardly perfect. People could fake what's on camera. In the age of AI, there are a lot of possibilities for the image not to be representing the reality. But what's your thoughts on either on camera use or use inside clinic as a way to mitigate, eliminate the diversion challenge?

[26:31]

CAULKINS: I'm very glad you're asking the question. So, I should clarify that everything I've said is about prescribed safer supply as practiced today, which gives take home doses of a week or two at a time, and there it is not supervised. If the doses were taken inside the clinic, I think the risk of diversion is negligible. And everything I just said does not apply. Providing prescribed safer supply inside a clinic is, from a market perspective, not really different than is medications for opioid use disorder like methadone.

You're raising the question of whether or not technology enables effective supervision outside of the clinic. And I think that is a very important question. You know, if I, like, controlled our research budgets, I might make studying that a possibility. Technology is awesome. Maybe we can do it. And if we can that would be fantastic.

But on the other hand, the creative energies of people trying to defeat the system and divert is also a very powerful force. And, which one of those ends up winning I think is a really good scientific empirical question that we ought to be investing in. Because if we can do supervision outside of the walls of a clinic, that could greatly increase the potential of the prescribed safer supply approach.

FELBAB-BROWN: And obviously expand the number of people who avail themselves of policy interventions that can stabilize their life, that can prevent overdose.

Now, is there a set of users that are simply drawn to the illegal market, even if they could be using at home with supervision that we just spoke about, they would not want to do it? Is there a segment of users like that? Do we have a sense of how large that segment is? Or is the illicitness part of the appeal, at least for some segment of users?

[28:30]

CAULKINS: Yeah, I don't know if I want to say illicitness is part of the appeal. But you are pointing to something very, very important, which is this giant treatment gap that we described between people who would qualify for substance use treatment and people who are actually enrolled in treatment is often imagined to be entirely because of a lack of supply of treatment. But it is also in part because of a lack of demand for treatment. There are there are many people who for various complicated reasons are not prepared to embrace treatment. Either they don't even show up to begin with, or they show up and they don't stay long.

And, that generates, as you well know, this enormous debate about what right does society have to shove people into treatment? On the one hand, treatment is a medical intervention, and the normal approach to human rights is to say you cannot compel people to receive medical treatment they don't want. On the other hand, the thing you are treating is not only a medical condition. The thing you are treating is ongoing, active violation of felony laws in ways that channel large amounts of money to violent criminal organizations that commit murders and undermine democratic institutions.

So, it just not a victimless crime to be a ongoing customer of violent, illegal markets. And that creates an ethical collision about the rights of people who want to be protected from illegal markets to compel people who do not want to volunteer for treatment to enter into that treatment.

FELBAB-BROWN: And countries have very different responses. Without implying any kind of endorsement, China does continually practice compulsory treatment for even situations where people do not have substance use disorder, they're simply identified as having used without having developed the problem. And might well end up in either what they call community supervised treatment centers, where the demand, the compulsion to stay, is at least two years, or isolation-based treatment where people stay for three years and then they have to go for another two years to the compulsory treatment. So, very aggressively enforced, very aggressively compelled treatment even for people who do not have a chronic illness, who do not have substance use disorder. Very different approach than in the United States.

[31:09]

CAULKINS: Yeah. The fact that some countries are able to do things that are unconscionable violations of human rights and are just grotesque has in some sense given a bad name towards incentivized treatment that is entirely different in its realities.

To be concrete about this, or maybe a little afield from the original focus, but what do we do when doctors or pilots or other skilled professionals develop substance use disorder? We do actually use incentives to push them into achieving recovery. And those programs have very high success rates. And they are not by most people's view unethical. And the question is whether or not we can have similarly high expectations and hopes for recovery for people who are not highly skilled professionals. It's a totally different world than what countries like China do. Tough love sometimes has high expectations.

FELBAB-BROWN: What you're saying, Jon, is that, you know, it's false to think of drug policy—whether one chooses supply, whether one chooses prescribed legal supply, whether one chooses law enforcement—as a simply technical enterprise that is devoid of politics. And these issues and decisions obviously need to be based on evidence. And we often talk about evidence-based treatment, evidence-based policies, many of which are elusive. But ultimately, they are judgments about conflicting ethics. They are judgments about conflicting harms. They are inevitably laden with politics and laden with moral choices.

And obviously, the purpose of the project, like our project on synthetic opioids, is to provide the best evidence possible across a wide range of approaches and to provide the recommendations, but knowing that, ultimately, politics and moral judgments will mediate, will influence the decisions that are made.

[33:18]

CAULKINS: I couldn't agree more. And really glad that you're stressing the conflicting interests. I think one of the ways that the drug policy debate of the 21st century in general has become impoverished compared to where it was when I got into the business is the willingness to recognize the legitimate interests of a wide range of stakeholders.

To a degree, the medicalization of the addictions problem in a Western tradition has put the individual with the substance use disorder at center stage to the exclusion of other valid stakeholders. And I include in that their families, and I include in that the general public that can suffer from the violence, corruption, the disorder of markets. And the integrity of democratic institutions that are threatened by these illegal markets.

The reality as a policy problem is that there are many conflicting interests at play. When you medicalized in a Western tradition that sees the patient as an individual only and not as part of a complex web of society, it can lead to an inability to simultaneously think about these multiple interested stakeholders.

FELBAB-BROWN: And of course, this change has come after years, decades when people with substance use disorders were seen as criminals, where they were denied access to effective medical care, where they often ended up in prison and stigmatized, as continues to be the case around the world. So, the corrective has perhaps gone way too far, but nonetheless came out of a real need of recognizing that people with chronic use disorders are human beings that need compassion and that need medical treatment.

Jon, let me ask you the final question. So, given the complexity of policy, the fact that they deliver the simplest intervention, that there were some positive effects and perhaps some negative or counterproductive effects, that there is no silver bullet. Where should U.S. policy focus today with respect to the fentanyl devastation? What is the most productive range of interventions that should be adopted?

[35:35]

CAULKINS: I think drug law enforcement should focus on controlling the violence, corruption, and disorder of the markets and protect the democratic institutions here and primarily abroad. I don't think that drug law enforcement should be focused on trying to put toothpaste back in the tube.

With respect to the people who now have opioid use disorder, I think we should throw at them all of the evidence-based interventions that we know about that encourage recovery. I am not enthusiastic about the idea that we should embrace futures of multiple decades of ongoing drug use for those individuals. I think the 5% or so annual risk of death is an inevitable consequence of the dangerousness of

fentanyl. It is not something that can be taken away by harm reduction. So, I view hostility to recovery as dangerous and having too low hopes and expectations.

But even when we do everything we can, the prognosis is not good for people who already have opioid use disorder. So, I think we should never underestimate the importance of trying to prevent further inflow into opioid use disorder. That includes continuing to be very careful about prescribing prescription opioids. It frankly includes a real investment in prevention and a willingness to say these drugs are just inherently deadly.

The fact that prevention overstated some things in the 1980s should not deter us from the frank and brutal honesty that in an era when fentanyl gets mixed into everything, every street drug is potentially dangerous. One pill can kill is not hyperbole. One pill can kill is the reality of the world that we live in, and we need to not shy away from giving that cold, hard truth to young people today.

FELBAB-BROWN: Thank you. It's a very important message, Jon. Terrific having you on the show. Thank you very much for your papers. We will be exploring in the other episodes of the podcast series many dimensions of the approaches you spoke about, from harm reduction to prevention, decriminalization, supply control, and law enforcement approaches beyond supply control, dealing with drug markets. Terrific having you with us today.

[music]

CAULKINS: Oh, it was an honor.

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.