SUMMARY REPORT:
GLOBAL SYNTHETIC DRUG THREATS REGIONAL FOCUS GROUP FINDINGS

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Executive Summary

Illicitly manufactured synthetic drugs such as fentanyl, tramadol, methamphetamine, captagon, MDMA, and ketamine present challenges across the globe. Synthetic drugs are both a public health and a public security concern, and solutions should involve diverse voices and insights from a range of key stakeholders including law enforcement, healthcare providers, mental health professionals, educators, researchers, and policymakers.

Between February and April 2024, the International Consortium of Universities for Drug Demand Reduction (ICUDDR) conducted 12 Regional Focus Groups with key stakeholders in six (6) global regions: Africa, Asia, Europe, Latin America, the Middle East, and North America. The first six Focus Groups (*N*=50) included university professionals and academic experts with specialized knowledge in substance use trends, patterns of use in particular regions, at-risk and affected populations, individual and community-level consequences of use, and systems of care that address substance use prevention, treatment, recovery, and harm reduction. Findings from the first set of Focus Groups were organized into themes of key findings and were presented in each of the six regions to government and policy Focus Group participants (*N*=107) who similarly reviewed findings and provided reactions, input, and feedback for the final report. The goal was to glean insights and ideas to help inform global strategies and approaches in addressing the use of synthetic drugs and their consequences. Highlights from Focus Group participants:

- Emergence of novel synthetic "mixtures" of multiple substances, and the challenges this presents in identifying substances and their unique effects.
- Increases in polysubstance use and its complications for clinical care in patient screening, diagnosis, treatment, and harm reduction.
- Synthetic opioids, alone or in combination with other substances, and their concerning impact on overdose.
- Social, economic, and physical/mental health consequences of synthetic drug use on vulnerable populations, including:
    - Young people, including adolescents, young adults, and students
    - Economically disadvantaged, including those who are unhoused
    - Individuals with co-occurring mental health and substance use disorders
    - LGBTQ+ populations, commercial sex workers, and those at risk for HIV
- Weaknesses in data capture systems to accurately identify trends in substance use patterns, risks, vulnerable populations, and social and economic consequences of use.
- Need for improved quality of services and access, enhanced workforce development, and efforts to address stigma and policy barriers.
- *Prevention, Treatment, Recovery* and *Harm Reduction* services across regions need to be more comprehensive, better coordinated, and more responsive to individualized needs.
- Training the existing workforce to better identify and address synthetic drug use is only a temporary fix and doesn't address the structural issues of a workforce that needs on-going skills and clinical exposure to aptly respond to local needs; pre-service training and education delivered within university settings will help capacity-building and "upstream" development of the workforce.

Regional summary of number of Focus Group attendees, primary synthetic drugs and vulnerable populations listed below:

Africa (n=19)

- **Synthetic Drugs:** Pethadine, Tramadol, Fentanyl, Methamphetamine, Synthetic "mixtures"
- **Vulnerable Population:** Young people, unhoused individuals

Asia (n=41)

- **Synthetic Drugs:** Fentanyl, Methamphetamine, MDMA, Ketamine, Synthetic "mixtures"
- **Vulnerable Populations:** Young people, individual with co-occurring mental disorders

Europe (n=37)

- **Synthetic Drugs:** Methamphetamine, Ketamine, Synthetic "mixtures"
- **Vulnerable Populations:** Young people, individuals with co-occurring mental disorders, unhoused individuals, commercial sex workers

Latin America (n=44)

- **Synthetic Drugs:** Fentanyl, MDMA, Ketamine, Synthetic "mixtures"
- **Vulnerable Populations**: Young people (pre-teens & teens), unhoused indivudals, polysubstance users

Middle East (n=8)

- **Synthetic Drugs:** Captagon, Methamphetamine
- **Vulnerable Populations:** Young people (adolescents, students), indivudals with co-occurring mental disorders, LGBTQ+ populations

North America (n=8)

- **Synthetic Drugs:** Fentanyl, Methamphetamine, MDMA, Ketamine, Synthetic "mixtures"
- **Vulnerable Populations**: Young people, LGBTQ+ populations, indivduals with co-occurring mental disorders

Background & Objectives

Synthetic Drugs pose growing security and public health challenges. Globally, illicitly manufactured synthetic drugs such as fentanyl, tramadol, methamphetamine, captagon, MDMA, and ketamine are on the rise as they are cheaper and easier to obtain than plant-based drugs. Several synthetic drugs are more potent and more lethal than the plant-based substances (e.g., cocaine and heroin) that they mimic. Widely available chemicals allow for easy manufacturing and undetected transporting, and small quantities can generate strong profits. Synthetic drugs threaten all regions of the world and identifying solutions requires engagement and strategizing with multiple domestic and international stakeholders and sectors.

This project aims to bring together critical stakeholders to discuss ideas for collectively combatting this shared challenge by gathering input from academic and clinical experts and government and policy personnel. The goal of these Focus Groups is to compile input from each region and to develop and collate feedback and recommendations responsive to the specific synthetic drug issues in each area. The information gathered from Focus Group attendees will help inform strategies and approaches for combating/addressing synthetic drug threats and help establish priorities and actionable steps.

Objectives of the Focus Groups include:

Objective 1 Collect input from regional "voices" with expertise in emergent synthetic drug trends, manufacturing and production, and public health interventions;

Objective 2 Collate and summarize feedback and share regional findings with government and policy stakeholders to help inform local priorities, strategies and solutions to synthetic drug use.

Methodological Approach

Between February and April 2024, ICUDDR staff conducted 12 Focus Groups on Zoom with 157 attendees, representing 60 countries. **See Table 1.** ICUDDR staff recruited attendees from member universities in each of the six regions. Member universities disseminated an informational flyer to faculty and researchers with expertise in critical areas: drug demand reduction; supply reduction; epidemiology of regional synthetic drug use; public health approaches to substance use prevention, treatment, and recovery; harm reduction; criminal justice and law enforcement; co-occurring disorders; systems of substance use disorder (SUD) care; and pharmacology. Interested individuals registered online and were provided logistic information to join their regional session. Focus Groups were scheduled during regular work-day hours for each region. Fifty (50) faculty and university-based experts from 24 unique countries participated in the initial round of Focus Groups. **See Table 1.** Sessions lasted 60 to 75 minutes, were facilitated by a trained qualitative researcher, and were supported by four (4) ICUDDR staff responsible for recording, transcribing, note-taking, and coordinating all pre/post-focus group communication. Session questions targeted topic areas that aligned with the Global Coalition Work Group activities: (1) *Detecting Emerging Drug Threats and Use Patterns*; (2) *Preventing illicit manufacturing and trafficking of synthetic drugs*; and (3) *Promoting public health interventions and services to prevent and reduce drug use, overdose, and related harms*.

Table 1. Number of Focus Group Attendees by Region, Countries Represented

	Number Attendees (N=)	***Countries Represented (N=)***
Africa	**N= 12** University / Content Expert **N= 7** Government / Policy	**N=9** Eswatini, Mauritania, Kenya, Libya, Nigeria, Seychelles, S. Africa, Togo, Uganda
Asia	**N= 14** University / Content Expert **N= 27** Government / Policy	**N=9** Australia, India, Indonesia, New Zealand, Pakistan, Philippines, S. Korea, Vietnam, Thailand
Europe	**N= 9** University / Content Expert **N= 28** Government / Policy	**N=16** Austria, Belarus, Belgium, Croatia, Czech Republic, France, Greece, Hungary, Israel, Kazakhstan, Lithuania, Portugal, Spain, Sweden, Turkmenistan, Ukraine
Latin America	**N= 9** University / Content Expert **N= 35** Government / Policy	**N= 18** Argentina, Bahamas, Barbados, Belize, Chile, Colombia, Costa Rica, Ecuador, Guatemala, Guyana, Haiti, Jamaica, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, Uruguay
Middle East	**N= 3** University / Content Expert **N= 5** Government / Policy	**N=5** Jordan, Lebanon, Qatar, Saudi Arabia, UAE
North America	**N= 3** University / Content Expert **N= 5** Government / Policy	**N=2** Canada, US

Following the first set of Focus Groups, the ICUDDR team analyzed transcripts and identified several key themes related to regional use of synthetic drugs, patterns of use, risk populations, local drug supply, and gaps in workforce, access to care, services, & policy. Regional government and policy stakeholders were invited to participate in a second set of six Focus Groups where initial findings were shared and structured discussions guided additional input and feedback. Individuals participating in the *INL Global Coalition* were recruited to participate, and more than 100 (*N*=107) stakeholders from 49 unique countries attended the second round of Focus Groups. All sessions were facilitated by the same qualitative researcher, and supported by ICUDDR staff who were responsible for recording, transcribing, note-taking, and coordinating all pre/post-focus group communication. Session questions targeted the same topic areas and similarly lasted between 60-75 minutes. **See Figure 1.**

Figure 1. Themes of Focus Group Questions

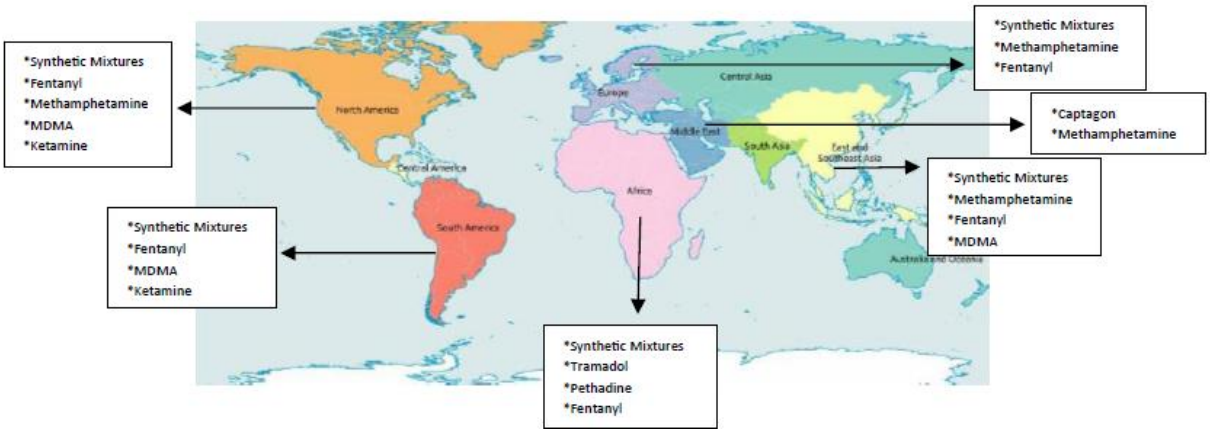
Focus Group Findings & Key Themes

Focus group findings are organized around the three Focus Group Themes: **(1) Emergent Drug Threats**; **(2) Preventing Synthetic Drug Manufacturing/Trafficking**; and **(3) Promoting Public Health**.

(1) Emergent Drug Threats: Use Trends, Patterns, and Risk Populations

Focus group attendees discussed the synthetic drugs most affecting their regions and the populations most at risk. Attendees discussed community use of synthetic opioids (e.g., fentanyl; tramadol) and synthetic stimulants (e.g., methamphetamine, MDMA), alone or in combination. Novel synthetic combinations, or "mixtures," were most concerning, and attendees across all sessions discussed emergent threats when combining synthetic opioids and stimulants. To a lesser degree, some regions reported limited use of synthetic cannabinoids and cathinones, alone or in combination with synthetic opioids or stimulants. Polysubstance use and combining different types of substances was normalized among substance users and was the most common emergent trend across regions. **See Figure 2.**

Figure 2. Synthetic Drug Use by Region



All six regions reported *Young People* as the key population most affected by synthetic drug use and the population most in need of targeted interventions. Some attendees expressed the greatest concerns about their *pre-teen*, *teen*, and *adolescent* populations (e.g., Europe, Latin America, Middle East, US). Others focused on *young adults* (e.g., Africa, Asia) and those of "productive age" (e.g., Asia) whose developmental milestones, such as becoming financially independent, were delayed due to substance use. Some attendees expressed concerns about specific regional trends in the use of synthetic drugs affecting sub-populations of *young people* such as *young men* (e.g., Africa, Asia), *young women* (e.g., Middle East), and high school and college *students* (e.g., Asia, Middle East).

Other populations vulnerable to synthetic drug use and its consequences include individuals with co-occurring mental health and substance use disorders. Attendees in nearly all regions (e.g., Asia, Europe,

Latin America, Middle East, US) expressed concerns about individuals with co-occurring disorders, as well as the unique effects of synthetic drugs on an individual's mental health. Economically disadvantaged and unhoused/unsheltered populations were cited by attendees in most regions (e.g., Africa, Asia, Europe, Latin America) as particularly vulnerable to synthetic drug use and their consequences, and attendees in several regions (e.g., Asia, Europe, Middle East, US) reported concerns about use within LGBTQ+ and commercially sexually exploited populations.

While attendees across all regions felt confident in identifying general emergent synthetic drug use trends and highest-risk populations most affected by use, several also noted the weaknesses in their data tracking and capture systems, making trend forecasting extremely challenging (e.g., Africa, Europe, Latin America, US). Some attendees shared that their data collection and early warning systems lacked the ability to meaningfully detect information on smaller regional trends, key populations, and health/social consequences of use because granular-level data collection was inconsistent and weak. Attendees in some regions reported on developments they had made in improving their data tracking systems with some focusing on technology improvements, and others tapping into their university systems and expertise to build capacity and sustainability of early warning/detection systems. Still, other attendees discussed measures taken in their regions to tighten the communication between various sectors (e.g., public health, mental health, education, law enforcement, etc.) capturing data on use or consequences of use.

(2) Preventing Synthetic Drug Manufacturing/Trafficking

Some regions had Focus Group participants with expertise in *Drug Supply Reduction* activities, and spoke knowledgeably on topics of local drug supplies, markets, manufacturing, transportation and traffic patterns. However, generally, attendees who participated in sessions were less seasoned in this area. Those volunteering to attend and share regional updates tended to work on the *Drug Demand Reduction* side and possessed professional expertise in the epidemiology and trends in substance use, and in public health promotion. Therefore, this section of the report is brief and relies on limited data contributions from attendees.

Local Drug Supply

Attendees shared that some synthetic drugs in their regions were manufactured locally, but often with materials and supplies from outside the country, mostly neighboring countries. In some instances, drugs like cannabis were grown locally, but then were traded for synthetic drugs, like MDMA, which were manufactured outside the country. Some attendees also highlighted the dangerous nature of synthetic drugs, such as methamphetamine, that are made using unregulated materials and inconsistent manufacturing approaches. Some also discussed the increases in physical health consequences of synthetic drugs, as well as increases in neighborhood violence and gang activity as demand for certain synthetic drugs increased. Noting this, attendees across regions commented:

- *For synthetic drugs, materials are coming from neighboring countries; synthetic drugs themselves are made in-country and supplied to urban areas because of such a strong market, but some of the supplies to make them are coming from outside.*
- *It's common to hear from the media that precursor foundations and materials are reformulated into fentanyl before or after coming across the border.*
- *Synthetic drugs can be made locally but it's not as good of a product. The methamphetamine industry is local, but we are seeing a lot of the materials coming from and moving through seaports.*
- *There are many clandestine production labs for methamphetamine right here in the country because we have a high number of chemical production labs.*
- *We have a lot of interested people in chemistry. They have experiences with production of these substances. We know of some collaboration between multiple neighboring countries, because some have the needed materials and some others have the information and understanding of the process to creating the substances.*

Noting the individual-level and community-level consequences of locally-manufactured synthetic drugs, some Focus Group attendees stated:

- *Anecdotal observation from my area shows that some of these drugs are locally made. The trend here is the use of cocktails—mixing items that are locally made with other substances on the market {alcohol and drugs}. This has led to many deaths.*
- *Substances are readily available and sold on street corners; young people purchase there. Young people are also being recruited into selling.*
- *We have a trafficking problem. We are seeing an increase in gang violence over dealing and supply.*

Imported Drug Supply

While some attendees reported on the local manufacturing of synthetic drugs in their regions –often using imported materials– others discussed the changes in their regional drug supply due to production and trafficking of substances from other countries. They reported multiple possible routes of an imported synthetic drug supply, including by air, sea, and ground. Discussing air and sea routes of synthetic drug trafficking, attendees shared:

- *We are seeing a lot of supply coming from seaports. For ecstasy/MDMA, it's produced in two border countries. We see some supply of synthetic stimulants, such as methamphetamine, being imported via airports and seaports.*
- *Drug smuggling is coming from [sea]ports and airports; we have several big ports here. And, we aren't winning that fight!*
- *Most illegal drug production and smuggling cases are coming from two neighboring countries, or through another neighboring country using small boats. It is a continuous process in and out of those countries and a continuous challenge.*

Highlighting movement of synthetic drugs via ground transportation, others noted:

- *Transportation workers, like drivers, have high use, and also support moving the supply.*
- *Synthetic drugs and materials are coming in by train and bus; large cities are sending drugs to smaller cities and we see use in public areas - parks, nightclubs, the community, etc.*
- *When it comes to synthetic drugs, rather than production, we are a consumption and transit country. Of where we are geographically, we are exposed to a high level of trafficking and a percentage of that stays in the country. We do not need to produce. We have little production here, but are a major transit point.*
- *We have a highway corridor through the Northeast down where there is a flow of illicit drugs*
- *We are a border city. We have the biggest meth seizure rate. It goes off the charts compared to other communities. I have a number of patients who are justice involved due to trafficking charges, and many are beguiled into trafficking fentanyl from our neighboring countries.*

(3) Promoting Public Health: Interventions and services to prevent and reduce drug use, overdose, and related harms

Focus Group attendees discussed several challenges when addressing synthetic drug use and promoting public health. Attendees in all regions discussed efforts to increase the access and quality of services, enhance workforce development, decrease stigma, and address policy barriers.

Quality of Services and Access Challenges: Improve Quality of *Prevention*, *Treatment*, *Recovery*, and *Harm Reduction,* and Access to Care

Prevention

Universally, attendees across regions expressed concerns about *prevention* services, generally, and services addressing synthetic drugs, in particular. Attendees referred to *prevention* as the "spine," "backbone," and "key service" in addressing synthetic drug use given that youth are the primary at-risk population. Yet, attendees across regions lamented that *prevention* services in their countries were inadequate in that they lacked an evidence-base, were not comprehensive enough, too weak and too infrequent to have a meaningful impact, were mismatched to the appropriate target population or target drug of choice or were not coordinated with other supports and systems at-risk youth need (i.e., mental health, education, etc.). Highlighting concerns about *prevention* weaknesses, and lack of comprehensive approaches, interviewees stated:

- *Prevention offered by my government isn't evidence-based.*
- *Our prevention isn't comprehensive at all; we need to bolster prevention work and focus on schools, families, university students, and others most at risk.*
- *We have big issues in the mental health of children and adolescents. We see big problems in school-aged children and school-aged kids, especially girls. Depression and anxiety are increasing, yet nothing addresses how these relate to risky substance use.*

- *Our kids need education and prevention programs, and we need to educate parents so they can detect the first signs of use among youth. We don't have resources for youth, resources are either not enough or non-existent.*
- *We have programs that focus too generally on drugs, alcohol, and tobacco. There are so many triggers in their lives that can lead to addiction including educational burnout, intimate partner violence, employment, stress. We are trying to create a network of resources that can address all of this.*
- *Substance use is a very complex issue. Prevention here is so limited other than a few school and university campaigns. For synthetic drugs, there are limited programs compared to cannabis for prevention and treatment.*

In addition to concerns about the quality and availability of *prevention* services in their respective regions, attendees also expressed concerns about the poor coordination of services, further hindering what limited services do exist. Expressing these sentiments, some interviewees stated:

- *Our prevention services are very disorganized and very regional. Any coordination across systems are non-existent.*
- *Across the spectrum of care, there is very little talking.*
- *I don't see a well-organized, concerted state-wide effort to do anything …nothing is very effective given the haphazard nature of the programs that are available. And, there is a lack of EBP given the complexities of novel synthetics.*
- *Prevention is financed by the government but provided by civil service organizations. We have efforts from various CSOs with a range of missions, so it is difficult with communication [between] care sectors.*

Treatment & Recovery

Similar to concerns with *prevention* services, attendees expressed that *treatment* services in their countries lacked a comprehensive approach, were too generalized, and not responsive to individualized needs or novel trends. In addition, *treatment* for substance use was frequently an unpaid or underpaid service, creating access barriers. Attendee quotes highlighting concerns about *treatment* weaknesses, and lack of comprehensive care to address changing drug trends and specialized populations, interviewees stated:

- *We need local effort and individualized effort. Big rehab programs here treat everyone the same regardless of substance. People with marijuana are being treated the same as people with meth.*
- *With polysubstance use and synthetic drugs, there are so many people who are struggling with mental issues, but they [programs] never talk about mental illness.*
- *When we talk about synthetic drugs, it's very young people, young adults or teenagers. It's difficult because they are young and we need to include the teachers in school, psychologists, social workers, and make treatment a better fit for them. Substance use is complicated, and we need involvement from different professionals in the field.*
- *Women use less but are still suffering and there are no treatment centers for women.*
- *Out-patient services in our country need to be very flexible about new substances and about where services are delivered to better attract young people.*

- *How can we treat [synthetic drug] use and what should we do with those children? We have discussed it and we don't see that it should be treated differently from other diagnoses. It's the same system, but for another drug, so we need to adapt and learn.*
- *We need recommendations on how to treat these patients. It's not a problem with treatment, per se. The big problem is we don't have complex treatment. We need more understanding, and it should involve social workers, psychological support, and have long term care that includes recovery support.*
- *Current programs are not full-service, and the systems don't communicate well. Mental health services are well-established, addiction science is emerging. Not all centers provide these services together.*
- *Some people need substitution therapies, so they need to be provided. But, we have to send our patients away for pharmacological interventions.*
- *We need better access to injectables and affordable pharmacotherapies. We have some funding for medications now, but less for the really hard and difficult root causes where mental services are needed.*

In addition to concerns with the quality, comprehensiveness, and responsiveness of their regional *treatment* approaches, Focus Group attendees also reported challenges with *access* to care. Across all regions, attendees shared the difficulties patients experienced in accessing care, largely due to costs and limited availability. In some regions, attendees noted that the only available treatment services are through the criminal justice system:

- *We have great services but not enough of them. And nothing for low-income people.*
- *Treatment is expensive in my country, yet most of those affected are low-income earners. Health insurance does not cover SUD treatment, so cost is often the biggest barrier. There is often no space available because there are so few spots in the first place.*
- *Substance use isn't covered by insurance, but mental health is. Treatment is expensive and not covered by the government; the patient must pay for it. Not all services are provided by the government, so there are self-paid options. There is a struggle to find funds to continue providing services and there is more need than what can be offered.*
- *Private sector treatment programs are self-pay with no insurance and are not certified.*
- *We have available treatment in the criminal justice system, but we are dealing with a long waiting list for treatment outside [of the criminal justice system*
- *There is support from the government in the court system. The cost of treatment is very high, and the drug court system reduces the cost to communities.*

Harm Reduction

Finally, attendees across all regions highlighted the need for better integration of *harm reduction* approaches into care. The acceptance and availability of with other systems of care. Attendees from regions with no or limited *harm reduction* services varied greatly across regions with some attendees reporting *a complete rejection of harm reduction as a viable approach to care in their* region, and others reporting having extensive services but lacking integration *harm reduction* stated:

- *We need Harm Reduction. Prevention still refers to total abstinence; education about public health is important. There is no harm reduction here. It is not applicable but is*

discussed at international meetings. They [government] encourage treatment. One will be exempt from prosecution if they accept treatment. But harm reduction is not possible.

- *In my country, harm reduction is very slow, but its acceptance is on the rise. For now, it's mostly just needle exchange, and only in urban areas.*
- *We offer antagonists now (naloxone) but it isn't used much and is not well-known.*

Attendees from regions where *harm reduction* was embraced stated:

- *Our government has responded by expanding harp reduction services. We provide drug testing kits, especially for populations known to use drugs in certain places (e.g., chem sex and dance/rave environments). We cannot analyze the drugs when they enter the country, or when they arrive to the final destination, so checking is important.*
- *We have test strips and are coordinating with law enforcement and others to distribute them widely.*
- *We are introducing some supervised consumption sites to help reduce overdose, and have established call lines to make sure people don't use [opioids] alone.*
- *Narcan is widely available and everywhere. As far as fentanyl, we have a lot of public service announcements. Our efforts are very focused on overdose prevention. There is a lot of attention on the fatality and mortality of fentanyl exposure.*
- *We need more established methods for integrating test kits and drug testing into communities. Testing and then fast-tracking into treatment. There is some in emergency rooms, but it is not comprehensive enough.*

<u>Workforce Development</u>

Attendees across regions discussed the need for training and technical assistance to upgrade the knowledge and skills of the existing workforce (e.g., counselors, nurses, physicians, educators, etc.). But, *in-service* training is only a temporary fix and doesn't address the structural issues of a workforce that needs requisite knowledge, skills, and clinical exposure to aptly respond to the ever-changing drug use and population trends. Attendees highlighted the need for expanded *pre-service* education and discussed the critical role of universities in developing a capable and competent workforce to address the range of substance use needs.

In-Service Training and Technical Assistance Needs:

- *We need to build treatment capacity and develop skills of providers who are in the field.*
- *We need to train on mental health and substance use human resources in the country, especially early on. Training is scarce. We have education for providers on alcohol and tobacco, but not for other drugs. The priority area needs to be evidence-based trainings for all people working in drug-related services.*
- *Our medical providers are not well-trained in substances. We are currently running a program on treatment and prevention, but some staff are not experienced.*
- *We have some larger organizations and governmental agencies, different health departments, and other NGOs working toward DDR. But skills vary and all the organizations lack coordination across our system of care.*

- *Our workforce is not properly trained in SUD treatment. Methamphetamine is a pandemic in universities; due to accepted use, there's also a related problem that most clients/people with SUD are showing psychotic symptoms. When they get help, they are not treating their SUD, they are giving antipsychotics without follow-up.*
- *In our region, the workforce is psychiatrists and psychologists. Some countries don't have regulations to license people. Some countries don't encourage work in the private sector. There is a need for certifying the workforce and for the government to work as regulators in providing these services. There is prevention and treatment but there is a lack of a trained workforce.*

Pre-Service Training & Capacity-Building: Several attendees argued for a transformation in how an addiction workforce develops the knowledge needed to skillfully deliver *prevention, treatment, recovery,* and *harm reduction* services. Universities can be critical in *pre-service* training and education and should play a larger role in ensuring that "upstream" skill development occurs. A system that relies solely on "re-training" the existing workforce may not be as current and comprehensive compared to one that is routinely infused with a younger workforce educated in recent trends and evidence-based approaches and interventions. Expressing these sentiments about *pre-service* education and capacity-building, attendees stated:

- *The role of universities in [training] the workforce is vital. In terms of prevention and treatment, both formal and informal education is a vital function of the university's role. The role of universities is crucial to training and capacity building. In addition to research, we are working on adapting existing evidence-based training to be culturally sensitive and responsive for our communities.*
- *We created a diploma program within our university for treating SUDs among healthcare professionals. We also created a diploma program for the management of SUDs and training for police in collaboration with the Ministry of Security & Safety. We have also created a master's course with the Ministry of Security & Safety to provide professional workforce training. We also support federal public policy advocacy.*
- *My university tries to handle training; however, no courses are offered on addiction counseling right now, so we have to find other organizations to train. We have lots of NGOs we rely on to help with this problem. Our Higher Education Commission has started a program for universities; our area is known for the production of synthetic drugs, so universities are working hard now to address this issue.*
- *Our Department is working hard to establish a Global Addiction Center. Right now we don't have professional staff working in the field, so relapse is very high.*
- *We have mostly an imported workforce. It is important to our government to train local professionals. Certified programs need to be developed and engagement is needed at the university-level to establish training within medical and nursing programs if we want to build capacity to handle this problem.*

Stigma & Policy

Across Focus Groups, Stigma was cited as a significant barrier to care and a key issue affecting the quality and type of services delivered by the SUD workforce, policy makers, and educators. Attendees cited several instances of stigma and its consequences on policy-making and clinical practice. Some highlighted how stigma resulted in substance use being punished rather than treated, and viewed as a criminal justice rather than a public and mental health issue:

- *We should take into consideration cultural practices, their [the patient] use of drugs, how that affects the community. We do not have a medical framework for mental health and substance use here. We punish it as a behavioral issue rather than treat it.*
- *There's a LOT of stigma and it creates barriers to accessing care.*
- *There is a lot of stigma around the disease; most people do not understand the problem and still treat it as a moral issue. We want to destigmatize the problem of substance abuse, especially among younger generations.*
- *There's lots of stigma around addiction and we need to learn how to help with this; there are lots of discussions among policymakers about addiction and how to address the issue.*
- *The Court System is well funded, but SUD treatment less so; private sector treatment is stronger but government funding is poor. So, stigma affects where people get care.*
- *We formed laws to try to emphasize alternative to prison for personal use offenses. And we try to use treatment if the person is not a dealer.*
- *Stigma affects who providers care for you and where it gets delivered.*

Conclusion / Recommendations

- Novel synthetic "mixtures" of multiple substances are increasingly common across the globe. These new drug combinations can be difficult to identify and present complications for clinical teams seeking to address their unique effects and consequences. We need to better understand the pharmacology of novel synthetic substances, and how to identify use and individual and community-level consequences.
- Synthetic opioids, alone or in combination with other substances, present a concerning impact on overdose risk. Strategies to reduce overdose risk and reduce the harmful consequences of use need to be implemented. This may include increasing the availability of Narcan/Naloxone, disseminating drug-test kits, and increasing the educational and prevention messaging to general and targeted populations.
- Some target populations are at highest risk and most vulnerable to the social, economic, and physical/mental health consequences of synthetic drug use. Such vulnerable populations, including adolescents, young adults, unhoused individuals, those with co-occurring mental health and SUD, and LGBTQ+ populations, need targeted attention to ensure they are receiving access to appropriate *prevention*, *early intervention*, *treatment* (including medications for addiction treatment), and *recovery support* services.
- Existing weaknesses in data capture systems have hindered thorough and accurate data collection to help identify trends in patterns, risks, vulnerable populations, and social and economic consequences of use. Many regions report on the challenges of meaningfully tracking granular-level trends. Improved methodologies and approaches to tracking and capturing / managing trend data would help teams identify risks, needs, and solutions. Tapping the epidemiological, technical, and clinical expertise of university personnel within regions may support building capacity and sustainability of early warning and detection systems, and public health interventions.
- *Prevention, Treatment, Recovery* and *Harm Reduction* services across regions need to be more comprehensive, better coordinated, and more responsive to individualized needs. Synthetic drug use, polysubstance use, and drug "mixtures" present new challenges to service delivery. Public health approaches cannot be "one size fits all." They need to be comprehensive and include a range of professional and para-professional expertise (e.g., physicians, nurses, therapist, counselors, educators, peers, advocates, policy-makers, pharmacists, etc.), and need to be more responsive to unique needs of patients most at-risk. Addressing synthetic drug use in a comprehensive and coordinated way will require several systems (e.g., justice, education, healthcare, mental health) to communicate and collaborate in strategic ways to ensure continuity of care.
- *Pre-service* training is critical and preparing the "up-stream" workforce is necessary to comprehensively address synthetic drug threats. Re-training and *in-service* educational opportunities are merely a short-term "band-aid" for the workforce. To address synthetic drug threats, and the threat of all novel drug trends, the field needs an on-going and continual supply of younger, educated providers who are skilled in the epidemiology of use, trends, and public health interventions and approaches. University partners within regions should be tapped to formally build and sustain infrastructure for multidisciplinary *pre-service* training and education to ensure a capable workforce.
- Although much of the synthetic drug manufacturing happens within countries where consumption occurs, Focus Group attendees claimed that the materials and components of

synthetic drugs came from neighboring countries. Efforts should be made to identify and control those "pre-cursor" materials, interrupting the manufacturing process.

- Attendees highlighted the multiple possible routes of imported synthetic drugs or their pre-cursor element, including by air, sea, and ground, presenting challenges for interdiction.
- Attendees across regions lamented that while *prevention* services should be "the backbone" and the "core" of their approach to addressing synthetic drug threats, instead their *prevention* efforts lacked an evidence-base, were non-specific, and were mismatched to the appropriate target population or target drug of choice. Resources directed at *prevention* should ensure that they are rooted in approaches supported by evidence, and are responsive to specific populations and trends identified as at-risk.
- Similar to concerns with *prevention* services, attendees expressed that *treatment* services in their countries lacked a comprehensive approach, were too generalized, and not responsive to individualized needs or novel trends. In addition, *treatment* for substance use was frequently an unpaid or underpaid service, creating access barriers. Given that those most in need of services are disproportionately lower income (i.e., youth, unhoused individuals, and those with a co-occurring mental health disorders), *Treatment* services should be universally accessible and not reserved for those who have the financial resources to pay for care.
- Attendees across all regions highlighted the need for better integration of harm reduction approaches into public health interventions. Synthetic drugs present serious threats to individual and community health; risk reduction and overdose prevention must be prioritized in order to save lives.
- Stigma was cited as a significant barrier to care and a key issue affecting the quality and type of services delivered by the SUD workforce, policy makers, and educators. Attendees cited several instances of stigma and its consequences on policy-making and clinical practice. Substance use and resulting consequences are experienced worldwide. Reducing stigma of substance use and acknowledging its global existence and impact helps communities embrace public and mental health approaches rather than relying solely on punitive and criminal justice measures to address threats.