Training Guide for Law Enforcement

Prepared for

Drug Control and Access to Medications (DCAM) Consortium

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APMG

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ACRONYMS

ADIS	Alcohol and Drug Information Service
ARHP	Asia Regional HIV/AIDS Project
CREDIT	Court Referral Education, Drug Intervention and Treatment (programme)
DCAM	Drug Control and Access to Medicines Consortium
DEA	United States' Drug Enforcement Agency
FDA	Food and Drug Administration
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
INCB	International Narcotics Control Board
L-AOs	Long-Acting Opioids
MAT	Medication-Assisted Treatment
NGO/s	Non-Government Organisation/s
NSP	Needle and Syringe Programme
NSW	New South Wales (Australia)
PMP	Prescription Monitoring Programmes
SCIR	Society for Community Intervention and Research
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

TRAINING GUIDELINES

Purpose

The Sessions in this training guide have been designed to support training workshops and provide information for trainers (ideally peer, law enforcement trainers). The 8 Sessions consist of slides, handouts and background information for law enforcement trainees to better understand the role of law enforcement in facilitating improved access to medical opioids. Trainers and participants should also be provided with the complementing *Law Enforcement Guidance* tool.

The training guide is an entry point for increasing knowledge and for examining issues related to the control of medical opioids and Medication-Assisted Treatment (MAT) in order to ensure availability for those with genuine need. By mixing theory and complementary activities, participants will gain an enhanced comprehension of the key topics.

The guide presents a range of requirements and approaches towards balancing the need to control opioids versus the need to ensure that opioid medications (including MAT) are available and accessible. These include United Nations (UN) Convention requirements, medical opioid supply issues, diversion control, and good practice in law enforcement towards improving access to medical opioids and MAT for those in need in communities and in prisons. Rather than prescribe specific ways for law enforcement to approach opioid control and availability, the training guide instead presents a range of models to be considered and which can be adapted for working with public health agencies to achieve improved balance in different country contexts.

Training Participants

This training guide is designed to provide instructive information for all levels of law enforcement, particularly narcotics enforcement at the local, state and national levels, as well as drug regulators and corrections officials. It acknowledges that law enforcement personnel may be unaware of the critical role that they play as enablers to improved access to medical opioids for those with genuine need.

The training guide consists of six sessions aimed at operational level law enforcement officials. Two additional Sessions are also included. One, (Session 6) for drug regulators and higher level law enforcement policy makers and the second (Session 7) for corrections and prison officers.

Participants should have some or all of the following criteria:

- must be from law enforcement;
- good reading, writing and comprehension of English and/or local languages;
- good reporting skills;
- good communication skills;
- good working knowledge of opioid control and availability issues, and related sociocultural contexts.

Trainers

In order to achieve both balanced and sustained responses, it is recommended that the training guide be implemented through existing law enforcement training institutions and made available to appropriate service levels.

It is strongly recommended that trainers be from law enforcement backgrounds themselves in order to provide the credibility and rapport required for optimal delivery.

Most workshops require more than one trainer. It is recommended that each trainer read all the topics covered in the Sessions – from the beginning to the end – in order to gain a better understanding of the scope of each topic within the overall workshop. The trainers should also have a copy of the Law Enforcement Guidance tool which provides further context and referenced material to partner the training guide.

Before the workshop, arrange a meeting of all trainers to decide who is going to teach which topics. Some trainers feel more comfortable presenting certain topics than other trainers and, for the benefit of the trainer and the trainees, this should be taken into consideration.

Before each training day it is recommended that the trainer/s familiarize themselves with the topics to be covered for that day, by closely reading the relevant Session and preparing handouts and activities.

The Training Guide

Most of the sessions have been designed to cover a period of 60 to 90 minutes, which includes theory, discussion and/or activities and it is crucial that adequate time is given for these to occur.

The training Guide consists of a series of PowerPoint slide presentation. The text to accompany each slide is contained in the Sessions below. Handouts and case studies are also included and carefully sequenced at the conclusion of the

respective resource Sessions. These resource Sessions are rich in information, to bring credibility and scientific analysis to the issues being examined and presented.

Guest Speakers

It is recommended that a very high level law enforcement representative open and close the course to add gravity and authority to the content and to provide instruction regarding subsequent actions.

Ensure that people who are coming to speak to participants (for example, experts in the field of law enforcement, drug control, speakers on MAT or pain relief) feel comfortable about their role, understand that they have the right to disclose or not disclose personal information, and the right to refuse to answer questions they feel to be too personal. Clearly inform speakers, and reach some kind of an informal agreement with them on what they should speak about.

Evaluating the Workshop

Evaluation is an important part of the training process. A Workshop Evaluation Form that assesses the training (including theory, discussions and activities) is included in this resource. This will assist the trainer/s to assess participants' reaction to the workshop and to assess the effectiveness of the workshop. It is often useful to prepare a report based on the results of these forms to assist other trainers to provide similar workshops in future. Such a report should include:

- name of the workshop, which Session, where and when it was held;
- organisers and funders of the workshop;
- facilitators' names and organisations (where applicable);
- participants' names and some short information about them (for example, their title, job description, locality, etc.);
- trainers' comments on major issues that arose during the workshop;
- results of workshop evaluations, highlighting significant results; and
- recommendations for changes to course materials, methods, participant selection, etc.

Daily Evaluation Forms are strongly recommended to provide daily feedback on the way the workshop is progressing, and to provide trainers with information about possible problems and/or issues that can be addressed before or on the following day/s of training.

An example of the evaluation forms are found in Appendix A.

Workshop Completion Certificate

It is a good idea to distribute certificates to all participants on the successful completion of the workshop. It has often been reported that this small gesture of endorsement or recognition helps a great deal to boost the level of participation and motivation both during the workshop and afterwards.

Materials Required

Materials required to facilitate the training workshop include:

- LCD projector (for PowerPoint slides) or overhead projector;
- computer with PowerPoint slides or printed overhead slides;
- flipcharts, a stand, at least 10 marker pens (various colours);
- whiteboard or blackboard (plus whiteboard marker pens or chalk)
- training guide Session handouts and case studies for each participant;
- notebook for recording information or aspects of the Sessions not documented in the training materials;
- evaluation forms (daily/end of the workshop);
- certificates of completion;
- CD-ROM of the resource Session including each of the PowerPoint slides;
- CD-ROM of information resources that complement the training workshop.
- Copy of the Law Enforcement Guidance tool
- A prize (e.g. chocolates)

The DCAM Law Enforcement Training Program

Day	Time	Session	Duration	Topic
		Overview	60 mins	Welcome, Introductions and Overview of the Training Program
		Session 1	90 mins	Introduction to Law Enforcement and Access to Medical Opiods and Medically Assisted Treatment (MAT)
		Session 2	90 mins	Key Terms in Drug Use
		Session 3	60 mins	Understanding MAT
		Session 4	90-120 mins	The Role of Law Enforcement in Not Hindering Access by Prescribers and Dispensers, and by End-users, to Medical Opioids.
		Session 5	90 mins	The Role of Law Enforcement in Assisting Access by End-users to Medical Opioids
		Session 6	180 mins	The Role of Law Enforcement in Ensuring a Safe Supply Chain for Medical Opioids. *Only for Drug Regulators and Policy Maker Levels of Law Enforcement*
		Session 7	120 mins	Assisting Treatment Access for People in, and Released from, custodial Settings *Only for Corrections Officers and Prison Policy Makers*
		Session 8	90 mins	Conclusion and Wrap Up
			30 mins	Evaluation and Certificate Presentations

Session Content Overview.

SESSION 1 Introduction to Law Enforcement and Access to Medical Opiods and Medication Assisted Treatment (MAT)

- Opioid medicines background and need
- Medication-Assisted Treatment (MAT)
- Balance: Drug control Conventions and medical access to opioids
- Law enforcement and medical access to opioids
- Human and health rights
- Implications for law enforcement

SESSION 2 Key Terms in Drug Use

- What is a drug and why do people use them?
- Drug classifications.
- Depressants: opium, heroin and morphine.
- Understanding potential effects and harms
- Factors influencing an individuals drug use
- The continuum of drug use
- Understanding dependency

SESSION 3 Understanding Medical Opioids for Pain Relief and Medication-Assisted Treatment (MAT)

- Opioids for pain relief
- MAT facts and benefits.
- Terminology check
- Access barriers
- Ways forward

SESSION 4 The Role of Law Enforcement in not Hindering Access by Prescribers and Dispensers, and by End-users, to Medical Opioids

- Responsible control of medical opioids
- Convention requirements
- Unintended impacts of diversion control: Fear of liability
- Unintended impacts of diversion control: Prescription monitoring
- Other unintended impacts of diversion control
- The law enforcement impact on access to MAT
- MAT regulations
- Important considerations towards developing diversion control regulations, policies and practices
- Guidance

SESSION 5 The Role of Law Enforcement in Assisting Access by End-users to Medical Opioids

- Working partnerships between law enforcement and health agencies

- Police concerns about MAT
- Building bridges with MAT and medical opioid providers
- Pre-arrest referral of people who use drugs illicitly to health and welfare groups
- Post arrest referral of non-violent drug offenders to drug treatment
- Guidance

Session 6 The Role of Law Enforcement in Ensuring a Safe Supply Chain for Medical Opioids

(for drug regulators and policy making levels of law enforcement)

- Summary of Drug Convention requirements: Import, export, cultivation, manufacture, storage, transport, dispensing and administration
- Preventing diversion of opioids
- The unintended consequences of diversion control
- Terminology and stigma
- Control to ensure availability: Case studies
- Control to ensure availability: Summary

SESSION 7 Assisting Treatment Access for People in, and Released from, Custodial Settings

(for corrections officers)

- The need for and benefits of continuity in treatment
- Concerns about MAT and medical opioids in prisons
- Case study exercises
- Policy and procedures
- Pain management
- Guidance points

SESSION 8 Conclusion

- Law enforcement and improving access to medical opioids and MAT – summary of guidance points
- DCAM website
- Key documents highlighted
- Evaluation

Training Curriculum

Opening Speech

A **high level law enforcement representative to welcome participants and explain the rationale for this training.**

10-20 mins

Welcome

Aims: To welcome and familarise participants to the training venue
Resources required: Nil
Time: 10 mins

Cover basic housekeeping such as the location of toilet facilities, availability of tea/coffee and expected breaks (recommended 15 minute break in morning and afternoon and 45 -60 min lunch break depending on time constraints).

Explain to group that shortly they will be given the opportunity to decide which rules will be followed in a later session.

Introductions

Aims:

- To discover what participants want from the workshop or training;
- To help the participants relax at the beginning of a workshop.

Resources: Pens and paper
Time: 30 minutes

Procedure: Split participants into pairs. Ask each partner to interview someone in the group that they have not met before (if possible) by focusing on the following questions:

- What is your name?
- What is your working background and your experience in this field?
- Why are you attending this workshop?
- What do you hope to get from the workshop?
- Name two good things that happened to you in the past year?

Each person is to write down the answers of their partner during a five minute interview. Each person is to then report to the rest of the group about their partner, summarizing the main information in one minute.

Comment: Participants are not reporting about themselves and so are less inclined to be nervous. It minimizes inhibitions about seniority. Participants interview those that they have not met before regardless of their position.

Overview of Training Program (10 mins)

Time: 10 mins
Resources： Session Plan for the program
Handout: DCAM Law Enforcement Training Course

Distribute participant copy of the course. Read through the outline, briefly describing each session. Ask group if there are topics that are not mentioned that they would like covered if there is time. If so, would they be prepared to come in early, leave late or adjust lunch breaks to suit?

Activity: The next activity is aimed at establishing rules for the training program.

Ask participants to brainstorm some rules they would be willing to follow for the course. Depending on the cultural and the specific characteristics of the workshop participants, the trainer may want to consider rules such as:

- We, the participants and trainers, agree to arrive on time for the beginning of each session and after each break;
- We undertake to honestly state our opinions, despite differences in rank, so that we can benefit from frank discussion;
- Participants may ask questions freely at any time, particularly if it is considered urgent, to clarify points – if it is not urgent, questions could be asked at the conclusion of a particular session;
- One person speaks at a time ; it is also important to ensure that quieter voices are heard in both small groups and plenary sessions;
- Comments should be made to the whole group – we undertake not to have side conversations with people sitting nearby;
- We undertake to listen to a person's full opinion or ideas, not react immediately – in this way we can consider what we really think of a new or opposing idea, instead of just reacting to it;
- We will work towards resolving conflicts rather than taking up inflexible positions;
- We will discuss ideas or opinions, and not the person expressing them;
- No smoking in the training room;
- No alcohol or drug consumption during the workshop sessions;
- We agree to switch off mobile phones in the training room;

- No violence (verbal or physical) – people must feel free to express opinions that may not be popular so that we can learn from these opinions.

Handout: The Drug Control and Access to Medicines (DCAM) Consortium Law Enforcement Training Program

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		Evaluation	30 mins	Evaluation and Certificate Presentations

Session 1- Introduction to Law Enforcement and Access to Medical Opioids and Medication Assisted Treatment (MAT)

Aims: To introduce participants to the role of law enforcement in achieving balance between access to opioid medications and MAT, and drug control.
Time: 60 mins
Resources: Slides, white board, butchers paper, marker pens, blue tac.

Slide 1 - Introduction

- Law enforcement have a central role in drug regulation and control
- This must be balanced with:
  - ensuring the availability of opioid medicines for those in need.
  - controlling illegal use while not restricting legitimate use.
- It has been common for law enforcement to focus on control, at the expense of legitimate access.

A functioning medical opioid supply and delivery system requires law enforcement officers to differentiate between good medicine and drug trafficking, and to effectively identify and control key sources of diversion.

Trainer Notes: Go through each point carefully. Ask if there are any questions. Explain that this Session will go into more detail on the need for balance, and also provide an overview of central subjects including opioid dependency and the scale of need for MAT as well as opioids for pain relief.

Activity: (20 minutes)

Explain that this activity is used to draw out a list of actual and potential law enforcement policies and practices which can impact on limiting access to MAT and medical opioids for pain relief. It is not a 'blame game', but a non-judgmental method used to better focus on the topic at hand.

Break into small groups of 4-6 and brainstorm the ways in which police practices may restrict access to medical opioids and MAT (10 mins).

Following this discussion, list policies and practices identified as a united group. Place this list prominently in the room so it can be seen for the rest of the course.

The list can include (depending on the jurisdiction involved) but is not restricted to:

- restrictive regulations set by Home Office or law enforcement drug regulators (ask participants to list some or all of them, and if there is extra time available, include discussion around which of the regulations are specifically required by Drug Conventions)
- strong enforcement of regulations
- police activity in or near MAT clinics
- police registration of patient names

Slide 2 - World Health Organisation recommendations for law enforcement

The law enforcement sector is encouraged to better support appropriate access to opioid medicines with attention to:

- ensuring that not interfering in appropriate access to medical opioids is an explicit goal of law enforcement practice, in balance with control of illegal use;
- that the policing of opioid prescription is conducted with well informed sensitivity for the diversity and importance of discretion in physician decision making;
- that activities that would deter people who inject drugs from seeking MAT and other forms of drug treatment and public health services are avoided;
- that MAT is available within the criminal justice system through diversion programmes or prison health services.

Trainer Notes: Law enforcement personnel can and do hinder access to medical opioids and MAT, but equally can play a key role in reforming and streamlining legitimate access without compromising effective policing of drug diversion.

This will be examined in much more detail in this course, but first we will look at the scale and urgency of achieving a better balance between opioid control and access.

Slide 3 - Opioid medicines and MAT: Background and need

- Much severe pain goes untreated in many countries
- Necessary opioid medications are frequently inaccessible
- People who inject drugs face extreme difficulties in accessing MAT (Medication-Assisted Treatment) for opioid dependence

Trainer Notes: It has been estimated that 6 million people suffer from severe untreated pain resulting from cancer and HIV, with millions more suffering in a similar fashion due to chronic illness, accidents and injuries, and the aftermath of

surgery. Commonly the opioid medicines required to effectively manage and treat pain, and medication assisted therapy for opioid dependence are unavailable, or remain largely inaccessible to those in need.

Globally, only 8% of people who inject drugs have access to harm reduction programmes, with less than 1% of this population covered by medication assisted therapy (MAT) for opioid dependence. Yet between 11.6 million and 15.9 million people are currently estimated to inject drugs, with approximately 80% of injectors living in developing and transitional countries. The rapid expansion of HIV, HCV and HBV epidemics among people who inject drugs can be largely attributed to the sharing of injecting equipment. Up to 10% of all HIV infections are estimated to result from injecting drug use. This means that that may be up to 3.3 million people who inject drugs living with HIV.

Poor access is related to a combination of factors, usually including weak health care systems, insufficient medical training in opioid use, stigmatisation of opioid use, cost and distribution, cumbersome regulations and legal.

Slide 4 - Medication-Assisted Treatment (MAT)

- Medication-Assisted Treatment (MAT) is a cost effective and evidence based treatment for opioid dependency
- MAT programmes have been implemented in comparatively few countries
- MAT programmes are often very small scale and/or pilot programmes
- Access to MAT continues to be unnecessarily impeded
- The impact of impeding access to MAT is particularly pronounced in developing and transitional countries

Trainer Notes: Although scientific evidence shows that MAT is the most effective (and cost effective) option for opioid dependence treatment with regard to HIV prevention, treatment and care of drug users with HIV, access to MAT continues to be impeded by several factors, including:

- poor availability;
- limited funding and/or government support;
- limited capacity within countries to delivery MAT;
- stigma, discrimination and ideological / moralistic views related to drug use and dependency;
- restrictive inclusion criteria;
- cost associated with MAT (including transport to dispensing site);
- lack of MAT patient confidentiality / privacy;
- legislation or strict regulations prohibiting or negatively impacting upon MAT.

Explain to trainees that limited access to MAT has occurred for a range of reasons, but that in many countries part of the restriction in access is due to a range of police practices.

Slide 5 - Balance: Drug control Conventions and medical access to opioids

- International treaties require opioid medicines to be accessible for those in medical need
- National drug control policies must therefore ensure a balance between drug control and medical opioid availability

Trainer Notes: Despite international treaties and national laws which allow – indeed oblige – access to opioid medicines for the treatment of pain and drug dependency, palliative care needs are poorly serviced.

The Single Convention on Narcotic Drugs endorses the adequate availability of medical opioids, while simultaneously preventing the illicit opioid production, trafficking and use. In addition, the INCB and the WHO have both endorsed the principle of balance for use in assessing national drug control policies.

Activity: (20 mins)
Depending on numbers, break participants into smaller groups of 4-6, preferably those who work in the same division or unit. Ask them to discuss and then write on butchers paper the following:

- What are the main issues you encounter in your job now in relation to MAT and medical opioids?
- What do you think is the cause?
- What strategies do you employ to address these issues?
- What works? Why?
- What doesn't? Why?

Slide 6 - Human and Health Rights

- MAT and medical opioid provision should be guided by the principles of human and health rights, flexibility and easy access
- Individuals are more vulnerable to HIV infection when their economic, health, social, or cultural rights are not respected.
- An overly punitive or criminal justice based approach can seriously undermine medical opioid prescription and/or MAT provision

Trainer Notes: Other guiding principles and approaches of particular relevance to MAT provision are articulated in the UN Drug Control Conventions, the Declaration on the Guiding Principles of Drug Demand Reduction and UN human rights and health promotion policies. These highlight that:

- protection of human rights is critical for preventing HIV as people are more vulnerable to infection when their economic, health, social, or cultural rights are not respected. Equally, a punitive approach, overly reliant on criminal justice measures, succeeds only in driving underground those people most in need of prevention and care services;
- flexible, easy-to-access MAT is critical to meeting the needs of heroin dependent people.

Balance means that the important responsibility to prevent illicit drug trafficking and abuse must not interfere in ensuring that therapeutic opioid medications are available and accessible to patients suffering from pain or drug dependence.

Drug control measures that hinder opioid availability and patient access to effective pain care and/or to MAT would be considered out of balance and should be identified and corrected.

Slide 7 - Balance: Drug control Conventions and medical access to opioids

- The INCB, the WHO and the UNODC all endorse a balanced approach to matters of drug control and MAT provision
- Restrictive drug control laws, and practices contribute to untreated pain and untreated heroin dependency
- Fear of legal sanctions among doctors and healthcare personnel also undermine pain treatment and drug dependency treatment

Trainer Notes: The recent United Nations Commission on Narcotic Drugs (UNODC) session also emphasized that drug control conventions seek a balance between ensuring the availability of opioids for medical and scientific purposes and preventing their diversion. It encourages Member States to consider ways to leverage existing health and development programmes in countries without adequate availability of opioids for medical and scientific purposes.

At all levels it is increasingly recognized that unnecessarily restrictive drug control laws, regulations and practices, training shortfalls, weak healthcare systems, and apprehension among healthcare workers regarding legal sanctions for legitimate opioid prescription have combined to perpetuate untreated pain and heroin dependency in many jurisdictions.

Ask group if there any comments regarding the negative consequences of law enforcement on medical access to opioids and MAT

Slide 8 - Implications for law enforcement

- The role of law enforcement is key – not only as a component of international drug regulation and control systems, but as a facilitator of access to opioid medicines and MAT by those in need
- Law enforcement agencies play an important role in promoting, or inhibiting, healthy behavior
- Attitudinal changes among law enforcement personnel can help to support improved access to medical opioids and MAT

Trainer Notes: Law enforcement personnel can and do hinder access to medical opioids and MAT ***and*** can play a key role in reforming and streamlining legitimate access without compromising effective policing of drug diversion.

A functioning medical opioids supply and delivery system requires law enforcement officers to differentiate between good medicine and drug trafficking, and to effectively identify and control key sources of diversion.

Effective implementation also requires attitudinal changes among law enforcement officials to support reforms in practice.

To better understand the role of law enforcement in facilitating improved access to medical opioids, it is helpful to have a clear understanding of contextual issues relating to heroin dependency, MAT and opioids for pain relief.

Slide 9 - What drug is this?

"The sufferer is tremulous and loses his self-command; he is subject to fits of agitation and depression. He has a haggard appearance. As with other such agents, a renewed dose of the poison gives temporary relief, but at the cost of future misery."

Source: Cambridge Regius, Professor Clifford Allbut and WE Dixon, 1907

Ask the group to guess which drug is being mentioned. Write their answers on a white board.

Slide 10

Coffee

Trainer Notes: In 1700, King Charles of England banned coffee houses because they were considered hotbeds for 'gossip'. The ban lasted for 10 days before public revolt. However, during those 10 days, people who drank coffee were criminals and could be arrested for illicit drug use. This is also a good example to show that the legal status of drugs is not necessarily linked to the harm the drug may cause, but rather based on political or moral grounds.

Ask the group who would be 'criminals' because of this drug law? Summarise by saying that attitudes towards particular drugs and the people who use them, is often heavily based on their legal status (which changes over time). It can be helpful to consider the stigma attached to opiate use and opioid dependency, much of which is exaggerated and cloaked in media hype, and the negative impact this stigma can have in terms of understanding dependency and enabling access to opioids for those in need.

Session 2- Key Terms in Drug Use

Aims: To increase the knowledge of participants of different types of opioid drugs, their short and long term effects and the factors that influence their use.
Resources: Slides, butchers paper, marker pens, white board.
Handouts: Opioids
Time: 90 mins

Trainer Notes: Tell the participants that you are aware that some Officers may have had experience in dealing with drug issues. There a lot of terms used throughout this session and the rest of the course. Some will be familiar to them but others will be new.

Activity: (10 minutes)

What is a Drug?

Ask participants to name all the drugs they can think of. List these on a white board in the following categories:

- Medical
- Legal
- Illegal

Trainer Notes: Brain storm with the group a definition which might cover all of the above.

Slide 1 - What is a Drug?

A drug is anything we take (apart from food and water) which will change the way we feel and/or behave.

Activity: (10 minutes)

Why do people use drugs?

Work in small groups and list on butchers paper all the different reasons that people may use drugs. (Give a small prize - for example a sweet, etc - to the group who comes up with the most reasons.) When complete, hang these sheets around the room.

Slide 2

Through out history people have taken drugs to alter their perceptions and change their moods; for the promise of instant pleasure, the possibility of heightened perception or simulated oblivion.

Drugs are taken to have fun, relieve pain, facilitate spiritual experience, enhance sex, or to escape from incapacitating poverty or other significant problems.

Activity: (15 minutes)

Drug Classifications

Ask : Do all drugs affect you in the same way? Are there categories of drugs (in terms of their effects)? The answer should be similar to:

NO. Drugs are not all the same. They can be very different in the way they are prepared, and in the effects they have on the drug user.

YES. There are three main categories of drugs, based on the effects of drugs on the Central Nervous System (CNS). The CNS consists of the brain and spinal column.

Slide 3 - Drug Classifications:

- Stimulants - increase activity of the CNS
- Depressants - slow down activity of the CNS
- Hallucinogens - markedly alter perception, mood and thought

Trainer Notes:

- ***Stimulants*** such as nicotine (in cigarettes), caffeine (in coffee and tea), amphetamines and cocaine: ***Depressants*** such as ethanol (in alcoholic drinks), morphine, heroin, diazepam:
- ***Hallucinogens*** such as cannabis and LSD (lysergic acid diethylamide) have the ability to produce a spectrum of vivid sensory distortions and also markedly alter mood and thought.

Slide 5-9 – Depressants include Opium, heroin and morphine

SLIDE 5

Opium

Traditional use traced back to 400BC by physicians

"A useful servant but a dangerous master"

Opium and Asia

- A shift from injecting to smoking with the introduction of tobacco from Portuguese traders
- Widespread use in China and India the 18th century

Base drug for morphine and heroin

Trainer Notes: Opium has long been used as a social and medicinal drug, and remains a corner stone of modern medicine today. Its earliest routes can be traced back about 7000 years when it was ingested by the ancient Sumerians. The ancient Egyptians used opium to calm crying infants. In 400 BC, Hippocrates used opium for a variety of illnesses.

Opium consumption was also recorded in Asia where a shift from oral ingestion of opium to smoking was witnessed after the introduction of tobacco by the Portuguese traders. Widespread use of opium did not become apparent in Asia until the 18th century when its manufacture, distribution and sale was largely under the control of the British East Indies Company.

In the late 18th century British merchants built up a flourishing traffic in opium from India to China which paid for Britain's imports from China, such as porcelain, silk, and, above all, tea. The Chinese government tried to curb the opium trade. In 1839, more than 20,000 chests of opium were confiscated and destroyed. The British merchants appealed to their government and in 1840, sixteen British Warships arrived in China and waged a two year war. The opium wars ended, and with the signing of the treaty of Nanking, the British were given Hong Kong, extra trading rights and £60 million in compensation for lost opium stocks.

SLIDE 6

Morphine

- Produced and distributed widely by pharmaceutical companies in the 1840's as an effective pain killer and a cure for opium dependency
- Warnings about addiction 1870 after intravenous administration
- (However data of opioid use in the treatment of pain reveals only a small risk of opioid dependence in patients who had no history of illicit substance use).

Trainer Notes: Morphine use has been traced back early in Greek history. The word morphine is derived from, 'Morpheus', the Geek god of sleep. As

controversy around opium intensified due to English trade practices in China and its growing popularity as a recreational drug in Europe, morphine gained greater popularity with doctors and their patients. Morphine was promoted as an effective pain killer and a cure for opium dependency. By the 1840's many pharmaceutical companies had begun wide scale production and distribution of the drug. It was not until the 1870's however when the first accounts and warnings about the dependent qualities of morphine were published. However, today, published data of opioid use in the treatment of pain reveals only a small risk of opioid dependence in patients who had no history of illicit substance use.

SLIDE 7

Heroin

- Alder Wright 1874
- Produced a more powerful but non addictive substitute for morphine
- Bayer 1898 "heroin"
    - Cough suppressant
    - Small oral doses
    - Cure for morphine addiction

Trainer Notes: Following the negative reports surrounding morphine, Alder Wright attempted to isolate a powerful, but non addictive substitute to morphine. In 1874, he boiled morphine with acetic anhydride and obtained a substance that received very little attention until 1898 when the German pharmaceutical company Bayer started marketing his discovery under the trade name heroin, named after the German word for hero, *heroisch.*

Heroin was initially promoted as a cough suppressant to be taken in small oral doses. Unlike the intravenously administered morphine, doctors prescribing heroin noted that heroin didn't seem to be habit forming and it wasn't long until heroin was promoted as a potential cure for morphine addiction!

'Heroin' remained a trademark of Bayer's until they were forced to give it up to France, England, Russia and the United States in 1919 as part of WW1 reparations.

SLIDE 8

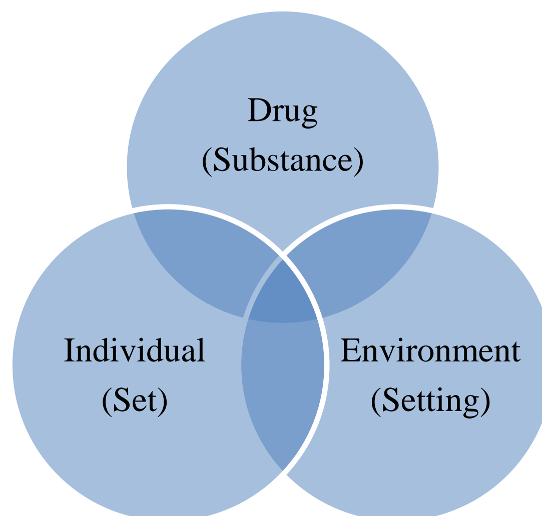
Heroin

- 1924 Porter Act in the USA
- Made the medical supply of heroin illegal

- Forced patients to obtain their drugs outside medical system
- Result – global drug trade

Trainer Notes: While heroin and morphine both lead to problematic use in many people their supply was mainly controlled through the medical system. However the passing of the 1924 Porter Act in the USA dramatically changed the way heroin and morphine were used and controlled. The Porter Act prohibited the manufacture and medical use of heroin in America forcing users to be cut off from medical support and to obtain their drugs from illicit sources. Overnight, the lucrative business of drug trafficking was borne.

Slide 9 - Interactive Model of Drug Use



Trainer Notes:

The Drug (or substance)

Drugs or any other external factors which people may use to enhance or change their emotional, physical or mental well being. ie. pain killers, caffeine, chocolate, opiates, anti-depressants, alcohol, exercise, meditation, food, sex and/or relationships. Other factors include the amount taken, strength, purity and route of administration.

The Environment (or setting)

Availability, cost, drug supply systems (legal and illegal): marketing, promotion, advertising, customs, laws and beliefs around the drug. Likewise, the individuals role, status, economic security, personal relationships will have an effect on the drug experience. Also drugs may have very different meanings in different settings: for example, wine is used in some Christian religious ceremonies in a

symbolic way, but is also drunk at bars by people who wish to feel intoxicated.

The Individual (or set) Heredity, genetic endowment, gender, size and body structure, fitness, physical health, food intake, nutrition, etc will have an effect on how an individual reacts to a particular drug. Likewise, their mood, feelings, temperament and personality will also have an effect. Their life experiences, memories, including previous drug experiences, sense of purpose, beliefs, attitudes, values around drug use are also significant. Expectations, motives and knowledge around drugs will likewise have an impact.

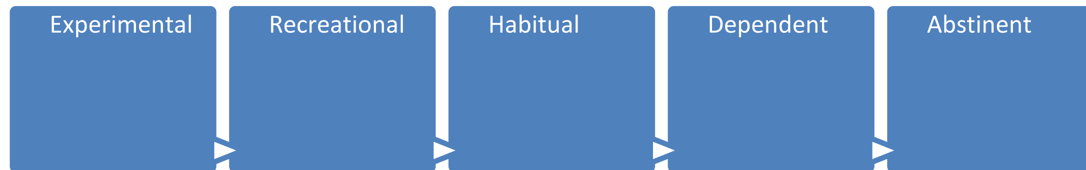
The interrelationship of these three factors is important when gauging the potential effect of a drug and the potential harms of a drug. Changing any one issue in any one factor can greatly alter the effect. For example, someone who is drinking alcohol at a party with friends who has an accident whilst driving home will have a different experience of the drug than if they were drinking by themselves at home. In this example, the set and substance stayed the same, but the setting changed. To give another example, two people are trying cannabis for the first time at a friend's house. One person becomes paranoid and nauseous whilst the other feels happy and talkative. Each person's drug experience was radically different, even though the substance and the setting were the same.

By examining ***Drug, Set and Setting*** in combination, levels of drug problems can be predicted and ascertained. In addition, strategies to control or reduce drug problems need to address these three areas together. It is for this reason that much traditional drug prevention and drug treatment fails. Drug prevention often concentrates only on the drug (assuming that all people will react to a drug in the same way in all settings), while drug treatment programs traditionally focus on the individual (self-esteem, will, behaviour modification). Neither strategy typically takes into account both the social and environmental factors that lead to initial drug use and that lead to ongoing or relapsed drug use.

Slide 10 – Factors influencing a person's drug use

- The drug
- The individual
- Traumatic and other significant life events
- Environmental issues
    - economic
    - cultural
    - schooling and other education
    - Surroundings (transport, neighbourhood qualities, public space)
    - social (laws, values, beliefs, levels of disadvantage, social cohesion)

Slide 11 – The continuum of drug use



Trainer Notes: The continuum should be conceptualised as a continuous line, rather than a set of steps or stages. People can move back and forth along this line. At certain points, drug use can be characterised in various ways.

Experimental: A young person who tries his or her first cigarette.
Recreational: A family who drinks wine with their evening meal.
Habitual: An office worker who drinks ten cups of coffee daily. A person who smokes 20/30 cigarettes per day.
Dependent: An alcohol dependent person who drinks a bottle of scotch to stave off withdrawal symptoms daily. An opiate dependent person who uses heroin and other substances on a daily basis.
Abstinent or Stopped using: At this point, the person has stopped using a drug. This period of abstinence may be long or short, temporary or permanent.

People can move from one category to another although some people establish a pattern and may keep this pattern for many years. One stage does not necessarily lead to another stage and there is little evidence to suggest that the use of one illicit drug leads to the use of other illicit drugs.

Some people start with a drug like nicotine or heroin and move through all these stages quite quickly towards dependency. But some people, like social smokers, will only smoke a few cigarettes at parties. Then at times of great stress (the end of a relationship, the death of a loved one, loss of a job), they may move further along the continuum. This also occurs with illegal drugs. Some people can have a level of control over their drug use, but when they are under great stress they may lose control and head toward the dependent end of the continuum.
Similarly, when people try to stop using drugs, they usually decide they must move immediately from dependent to not using drugs at all. This can be extremely difficult to accomplish and often leads to relapse, where they start using drugs again, either occasionally or they move very rapidly back to dependence. So people can change positions along this continuum quickly and often.

Finally, the same person can be at different points on the continuum when considering their use of different drugs. For example, it is quite common to find a dependent smoker who is only an occasional drinker. This also occurs with illegal drugs so that some people have a particular drug they usually take, which is called their drug of choice (point towards, regular, habitual and dependent) which may for example be heroin, but they may also take cocaine occasionally.
The most important point about this continuum of drug use is that drug users may be at various stages along this continuum and, over time, they may shift back and forth along it.

Slide 12 - Two key points

1. Experimenting does not necessarily lead to regular drug use.
2. Regular use does not necessarily lead to problems.

Trainer Notes: Emphasise the two major issues.

Slide 13 - Tolerance

- An increasing amount of the drug is needed to achieve the same effect
- Tolerance can be affected by:
    - An individuals weight and size
    - Illness or diseases, such as liver or kidney function
    - Duration of use
- First time or recreational users have lower tolerance
- Long-time users have increasing tolerance. However, tolerance can drop quickly after short break from drug use. E.G. Following detox or release from jail

Trainer Notes: A person is said to be tolerant to a drug when increased doses of the drug are needed to get the same effect or the continued use of the same dose gives a markedly diminished effect. Tolerance occurs because the body adapts to the presence of the drug.

Tolerance can present a number of problems for the user. For example, if a person becomes tolerant to a sedative /hypnotic, they may increase the amount taken to achieve the desired psychoactive effects but this amount may be too much for the body to cope with some other effects such as the respiratory depressant effect of the drug. Therefore, while increasing their dose to maintain the desired psychoactive effects, they may inadvertently take enough to cause respiratory arrest.

Slide 14 Withdrawal

If the user is dependent on heroin, physical withdrawal symptoms will be experienced as the body readapts to functioning without the drug.

Trainers Notes: Withdrawal symptoms from opiates include yawning, tears, diarrhoea, insomnia, stomach cramps, vomiting, goose bumps and a runny nose. These symptoms resemble a severe bout of flu.

Slide 15 - Dependence

Dependence can be psychological or physical or both.

- ***Psychological Dependence -*** People who are psychologically dependent on opiates find that using it becomes far more important than other activities in their lives. They crave the drug and will find it very difficult to stop using it.

- ***Physical Dependence -*** Physical dependence occurs when the body adapts to functioning with the drug present.

Trainers Notes: Clinical guidelines for a definite diagnosis of 'dependence' are detailed in the WHO's International Classification of Diseases (or ICD-10), and require that three or more of the following six characteristic features have been experienced or exhibited:

- a strong desire or sense of compulsion to take the substance;
- difficulties in controlling substance-taking behaviour in terms of its onset, termination or levels of use;
- a physiological withdrawal state when substance use has ceased or been reduced, as evidenced by – the characteristic withdrawal syndrome for the substance, or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- evidence of tolerance, such that increased doses of the substance are required in order to achieve effects originally produced by lower doses;
- progressive neglect of alternative pleasures or interests because of substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
- persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning – efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

Slide 16 - Understanding dependence

- Drug dependency is a complex condition encompassing a broad range of physical, psychological and social aspects
- Some opiate dependent people develop tolerance and need to take increasing doses of opiates to achieve the desired effect
- If a dependent person suddenly stops taking opiates, s/he will experience an uncomfortable period known as 'withdrawal'
- Some formerly opiate people can 'relapse' to drug use

Trainer Notes: A sound understanding of the basics of opiate dependency provides context for better medical management – including for offenders and prisoners who are opiate dependent – and for appreciating the role of MAT.

Drug dependency is a complex condition encompassing a broad range of physical, psychological and social aspects.

The majority of people who use illicit opioids (particularly heroin), or who are prescribed opioids for pain relief, do not become drug dependent. However, if opioids are used persistently for a significant period of time, some people may develop dependency. When people use opioids consistently and over time, adaptation in the body occurs in efforts to stabilize to usual levels. The body stops producing its own opioids (called 'endorphins') in an effort to regain the usual balance. This explains why opioid dependent people report needing to take increasing doses to achieve the same effect (i.e. 'tolerance').

If a physically dependent person suddenly stops taking opioids, it takes his or her body a few days to return to normal endorphin production levels. In the meantime, with no opioids or endorphins in the body, the person will experience an uncomfortable period known as 'withdrawal'. The degree of discomfort correlates with the degree of dependency or the size and frequency of a person's usual dose.

Activity: (20 mins)

Understanding Dependency

Inform group that there is increasing pressure to limit or reduce the use of fossil fuels. They cause pollution, degradation of the environment, wars and other significant issues. Cars themselves are a major cause of fatalities and mortality, etc. Facilitator comments that we know cars are damaging, we know that fossil fuels have major negative effects and yet we still use them. Ask group why is that? (It's convenient, accessible, familiar, etc) Then state that we are dependent on cars. And despite the risks, we still use them.

Then inform group that it has been decided that petroleum driven transport is going to be banned once the population have had sufficient time to address the changes required to cease using fossil fuels. Ask the group to break into groups of four. Ask them to brainstorm what they would need to change in their life if they were no longer allowed to use any form of petroleum based transport, this would include trucks, buses, taxis, motor bikes or any other vehicle powered by fossil fuels.

They are to consider three aspects:

- What changes they would need to implement (would they be able to get to work, could they still work where they do, how would the children get to school, shopping, recreation, sports, purchasing a electric car/bike, etc.
- How long it would take for them to implement that change? (week, month, year, many years?)
- What alternatives would need to be available to allow or maintain the change

Have a group discussion regarding what each group described. Highlight that some changes may take years to implement. For many, sudden sustained abstinence from petroleum based transport is unlikely. For many, alternatives would need to be provided until such time as they are able to give up petroleum based transport. For many, total abstinence may not be achievable.

Ask the group to consider the similarities with individuals who are drug dependent. For many, sudden sustained abstinence from their drug is unlikely. For many, alternatives would need to be provided until such time as they are able to give up their drug of dependence. For many, total abstinence may not be achievable.

Then ask the group to consider the following scenario:

It is a cold, rainy winter's evening. It is raining. They have just done the family shopping (or carrying a heavy load). They have been told the transport they had arranged isn't able to take them home. They are cold, wet, tired and just want to get home. As they look around, they see an old petrol driven taxi in a dark alley way. The driver indicates that he/she would be willing to drive them home, for a price, with little chance of being discovered.

Would they take the taxi? Why? Why not?

For someone to stop being dependent on fossil fuels, they have to identify what changes will be needed, have a time frame for these changes to occur and identify specific areas where alternatives will be needed. It is an ongoing process that is unlikely to happen overnight. The same process applies to individuals

who are dependent on drugs. Asking them to stop using immediately is unlikely to work.

While many people may successfully overcome the physical withdrawal symptoms associated with the cessation of heroin and opium use, the complex nature of drug dependency means that they may also experience a range of psychological cravings for some time. This is why 'relapse' can be common for many heroin dependent people. In the context of pain management, unrelieved pain can also precipitate relapse.

Slide 17 - Summary of key points

1. Most people use psychoactive substances
2. Some of these substances are illegal
3. There are different categories of patterns of drug use
4. Usually people use a certain drug because it has the effect they want or need
5. Some people use a drug because they are dependant - they use it to remove withdrawal
6. Many people use drugs in a manner which places themselves and others at risk.
7. Some drugs no matter how they are used are harmful - tobacco.
8. Many people who have been dependent have received help and now live productive happy lives

Handout: Opioids

Depressant drugs slow down the functions of the Central Nervous System and they affect concentration and coordination. In small quantities they can cause a person to feel more relaxed and less inhibited. In larger quantities they may cause unconsciousness, vomiting and, in some cases, death.

Some people classify the Depressants into groups such as sedatives or sedative hypnotics, opiate analgesics, anaesthetics, etc while others use different groups. Depressant drugs that can be classified as sedatives include: alcohol, barbiturates, benzodiazepines, and cannabis. Opioids (such as heroin, methadone, morphine, and codeine) can also be included in this group.

The following table provides information on opioids

Opiates	These are analgesics (pain relievers) and are derived from the opium poppy. Heroin: Heroin is derived from opium. It produces euphoria, dulls the awareness of pain, blocks the cough reflex, and depresses breathing. Morphine: Morphine is chemically similar to heroin and is principally used in the medical field to relieve severe pain. Codeine: Codeine is derived from morphine and is used to relive mild and moderate pain. It is often combined with analgesics such as aspirin or paracetamol. This combination is typical of some medicines sold as painkillers in shops.
Opioids	These are chemically similar to the opiates and have similar effects. Pethidine: this is a synthetic and strong analgesic (pain reliever) and has a quicker onset than morphine but a shorter duration. Methadone: this was invented by German scientists during the Second World War as a substitute for morphine.

Session 3- Understanding Medical Opioids for Pain Relief and Medication-Assisted Treatment (MAT)

Aims: Participants will develop a contextual understanding of the need for opioids for pain management and the rationale for MAT.
Resources: Slides, white board, butchers paper, marker pens
Handouts: Methadone
Time: 90 mins

Slide 1 - Opioids for pain relief

- Medical use of narcotic drugs is indispensable for the relief of pain and suffering, and that adequate provision must be made to ensure that such medicines are available
- Opioids are safe and effective for the relief of pain and treatment of dependence when prescribed by knowledgeable practitioners
- Pain can seriously undermine quality of life, and opioids are a primary treatment

Trainer Notes: The Single Convention on Narcotic Drugs of 1961 highlights that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering, and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes.

There is an international medical and scientific consensus that opioids are safe and effective for the relief of pain and treatment of dependence when prescribed by knowledgeable practitioners. Although experienced and reported differently by individuals, pain is a real phenomenon in the nervous system and its treatment should be taken seriously as it can seriously undermine quality of life. Not all pain needs opioids, but in some cases opioids are indeed the primary treatment.

Slide 2

A researcher who studied chronic back pain patients says his results support the theories of psychiatrist Thomas Szasz that chronic pain may become the "career" of patients who are "deeply committed" to the "sick role."

Activity: (10 minutes)

Break the group into small groups and ask each group to discuss what stereotypes does the comment reinforce regarding individuals with chronic pain. How might these stereotypes influence access to medical opiods for end-users?

Slide 3

- Terminology. Why we use Medication-Assisted Treatment (MAT) and not Opioid Substitution Therapy (OST)?
- MAT is currently the most effective treatment available for heroin dependence
- MAT offers physical stability in contrast to the often dramatic highs and lows that are associated with dependent illicit heroin use
- MAT helps to introduce stability and removes the stress associated with needing to obtain illicit heroin

Trainer Notes: Explain that medicines used for dependency therapy, such as methadone and buprenorphine, have sometimes been labeled 'Opioid Substitution Therapy' or OST. It is important to note that 'substitution' has sometimes been misunderstood and that this has contributed to stigma against, and reluctance to provide, such therapy. In fact, heroin and MAT medications have completely different pharmacological properties. Some scientists prefer to use the term Long-Acting Opioids (L-AOs) or simply 'maintenance agents', highlighting the pharmacological differences between L-AO medications and shorter-acting opioids such as heroin. For the purposes of this training, the American terminology of MAT or 'Medication-Assisted Treatment' is used.

Medication-Assisted Treatment, using long-acting drugs such as methadone or buprenorphine, is currently the most effective treatment available for heroin dependence.

Methadone and buprenorphine are the two most commonly used MAT medications for treating heroin dependence. Buprenorphine is at least three times more expensive than methadone, but can be provided in a drug combination form with naloxone (under the trade name Suboxone) which is thought to reduce drug diversion. Within one or two weeks of beginning MAT, most heroin users experience reduced craving, and over a period of time decrease or stop their use of heroin. MAT offers physical stability in contrast to the often dramatic highs and lows that are associated with dependent illicit heroin use.

Activity: (10 minutes)

Brainstorm with the group the following:

- How long should medical opioids be given to a patient for pain relief? Why?
- Should patients be removed from medical opioids for pain management? Why?

Write these on the white board, then repeat the exercise but with reference to MAT, as follows.

- How long should MAT be given to a client? Why?
- Should clients be removed from MAT against their will? Why?

Write these on a white board.

Slide 4

- MAT patients report less criminal activity, improved family ties, fewer attempts at suicide, less criminal convictions, and assisted adherence to HIV medication
- The longer that a person is in MAT treatment, the less likely they are to use heroin and, therefore, the better the outcome
- If a patient ceases MAT before s/he is ready, there is a high likelihood that s/he will relapse to illicit drug use
- MAT medications are listed by the WHO as 'Essential Medicines', and the INCB has pointed out that MAT "does not constitute any breach of treaty provisions"

Trainer Notes: Overall, the goal of MAT is to improve the health, social and economic outcomes for individual drug users, their families and the community.

MAT helps to introduce stability and removes the stress associated with needing to obtain heroin. The risk of contracting blood-borne viruses such as HIV, hepatitis B/C and other harms associated with injecting are reduced. People receiving MAT report less criminal activity, improved family ties, fewer attempts at suicide, less criminal convictions, and assisted adherence to HIV medication.

Of particular significance is the length of time in treatment and the dose. The longer that a person is in treatment, the less likely they are to use heroin and, therefore, the better the outcome. MAT is a long term rather than a short term treatment. While people do eventually cease MAT, if they do so before they are ready, there is a high likelihood that they will relapse to illicit drug use. Evidence suggests that the minimum period for effective methadone treatment is 12 months, but for some people treatment may be life-long. Therefore, remaining on methadone is not seen as an indication of failed treatment.

The use of MAT is supported by the UN system as an essential element in the management of heroin dependence and the prevention of HIV infection among injecting drug users. MAT medications are listed by the WHO as 'Essential Medicines'. The INCB has pointed out that MAT does not constitute any breach of treaty provisions, whatever substance may be used for such treatment in line with established national sound medical practice.

Activity: (5 minutes)

Refer back to brainstorming exercise and ask group to comment now on the following:

- How long should MAT be given to a client? Why?
- Should clients be removed from MAT against their will? Why?

Ask participants if they have any questions related to the material presented or the material in the handouts on MAT.

Slide 5

- Many of the regulations restricting access to medical opioids were adopted before dependence and the beneficial medical uses of opioids were understood
- Many national drug policies reflect disproportionate concerns that the use of opioid medications in pain management will be diverted to illicit markets and result in patients becoming opioid dependent
- Physicians are often deterred by the fear of stigmatisation and professional discipline, criminal sanction or even imprisonment for mistakes in opioid dispensing or record keeping
- Laws and law enforcement practices have unfortunately hampered the goal of medical availability of opioids

Trainer Notes: Systems of control and outdated understandings of drug dependency have interfered with safe patient access to medical opioids and MAT, and defeat the purpose of the Conventions.

From the 1920s on, international agreements began to control the supply of certain drugs. Medicinal drugs in most countries had by then come under the control of doctors (through prescription) and pharmacists (for those medications which did not need a prescription).

The early focus of international attention was on illicit drugs, principally opium. Throughout the next few decades, these treaties and conventions attempted to

ensure that opium was not trafficked between countries and that opium production was restricted.

While efforts to address those who illegally divert controlled medicines are a legitimate target of law enforcement, some policies have had unintended negative effects on patient care, drug treatment and medical practice. Physicians are also deterred by the fear of stigmatisation and professional discipline, criminal sanction or even imprisonment for mistakes in opioid dispensing or record keeping.

Law enforcement efforts to curb diversion of opioids are important. Unfortunately, laws and law enforcement practices have hampered the goal of medical availability. A streamlined approach, based on international drug conventions, is required in order to adequately address the complexity of medical opioid access. Strategic partnerships which allow the health and welfare sectors to interact with law enforcement are also required.

Slide 5 - Law enforcement barriers to MAT access

- Law enforcement activities have often acted as a barrier to MAT
- Law enforcement often perceive MAT clinics as being part of the drug problem and act accordingly by arresting patients as they leave legally prescribed medical treatment
- These obstacles can be avoided if informed by a sound understanding of the rationale of medical approaches to the treatment of opioid dependence.

Trainer Notes: In the main, law enforcement have often been under-informed about the medical approach to the treatment of opioid dependence. Law enforcement have often perceived clinics as being part of the drug problem and acted accordingly by arresting patients as they leave legally prescribed medical treatment. This has been observed during recent years in Malaysia, China, Kyrgyzstan, Ukraine, and Thailand, and is clearly indicative of the need for law enforcement to adopt policies that support the medical treatment of drug users.

There is commonly a dissonance between law and practice on the streets. Law enforcement authorities have started to digest the implications of HIV/AIDS but harm reduction programmes are yet to be integrated in practice.

A balance must also be struck between carefully conceived reform of policy and thorough and sustainable implementation.

Slide 6 - Ways forward: guidance points.

- A holistic approach is needed to address the complex issue of medical opioid and MAT access
- Strategic partnerships between the health and welfare sectors and law enforcement enable interaction
- Local level partnerships are also required
- Law enforcement can often provide better support for appropriate medical opioid access without compromising effective diversion control duties.

Trainer Notes: Clearly a system of control that interferes with safe patient access to medical opioids defeats the purpose of the Conventions and the controlled drugs regulatory system. A holistic, rather than narrowly-focused, approach is required in order to adequately address problems of the complexity of medical opioid access.

Strategic partnerships are required which allow the health and welfare sectors to interact with law enforcement, as are local level partnerships that focus upon the personal and social dimensions of drug use in the context of health models for disease prevention.

Explain that the role of law enforcement, not only as a key component of international drug regulation and control systems, but as an enabler of access to medical opioid access by those in need, and as one component of a holistic approach, will be explored in this training. Specifically, the training will focus upon the role of law enforcement in:

1. ensuring safe manufacture, transport and storage of medical opioids;
2. not hindering access by prescribers and dispensers, and by end users, to medical opioids;
3. assisting access by end-users to medical opioids;
4. assisting ongoing treatment for people in prison and for released prisoners.

Handout – Methadone

(NB: Additional information is provided here on methadone as the most researched, most frequently applied and most inexpensive MAT treatment. Information on buprenorphine can be sourced at a number of sites: e.g.: http://www.druginfo.adf.org.au/druginfo/drugs/drugfacts/buprenorphine.html).

Opioid medicines such as those used for opioid dependency therapy, such as the synthetic opioid, methadone, and the semi-synthetic opioid, buprenorphine, have sometimes been labeled 'Opioid Substitution Therapy' or 'OST'. It is important to note that 'substitution' has sometimes been misunderstood and that this has contributed to stigma against and reluctance to provide such therapy. Some scientists prefer to use the term 'Long-Acting Opioids' (L-AOs) or simply 'maintenance agents', highlighting the pharmacological differences between L-AO medications and shorter acting opioids such as heroin. For the purposes of this document, the US terminology of 'MAT' or 'Medication-Assisted Treatment', has been applied. MAT programmes have been implemented in 73 countries worldwide, and even in countries that have implemented such programmes, treatment is often provided at very small scale or on a pilot basis and not as part of a national policy.

Methadone is a legal, synthetic opiate drug. It is used as a medication that replaces heroin in the body, and therefore reduces craving for heroin and withdrawal symptoms. Its effects last much longer than heroin. A single dose of methadone can be effective for approximately 24 hours whereas the effects of heroin may last for only a couple of hours.

People who use methadone as a maintenance therapy take it in liquid form once every day. Doses vary from person to person, but most people will start on a lower dose of about 20mgs increasing to 40 – 80 mgs on average. The person may then stay on the same dose for as long as needed, sometimes the rest of their life, and others will stop using methadone when they decide they no longer want to use it.

Methadone helps people function in their daily lives because;

- They only need to take it one time per day
- Methadone is legal
- Methadone is usually more affordable than heroin use,
- Methadone doesn't give people the same 'high' as heroin, making general functioning easier
- Methadone stops the withdrawal symptoms when going off heroin
- Methadone can reduce craving for heroin for some people who use it.

Additionally, methadone:

- Reduces criminal activity for individuals and communities

- Reduces HIV and other blood borne virus transmission
- Encourages people to lead a balanced and stable lifestyle including improved diet and sleep due to the routine involved in methadone treatment.

Methadone *does not*:

- Damage people's bones, teeth, or body organs
- Damage the baby when the father or mother uses methadone when the baby is conceived, when the mother is pregnant or when the mother is breastfeeding
- Make a person addicted to opiates for the rest of their life.

Methadone maintenance therapy works best when the client chooses to go on methadone voluntarily; has has other kinds of support, such as family support and counseling; is on an adequate dose; and is allowed to continue for as long as they wish.

Methadone deaths are rare. Methadone related deaths have almost always been due to combining methadone with other drugs, particularly benzodiazepines such as Valium and Rohypnol, and/or alcohol.

It is generally accepted among health professionals that methadone treatment is effective in reducing deaths among heroin-dependent people. Deaths involving those in methadone treatment have occurred mainly due to accidental overdose, suicide or accidents, including those involving a motor vehicle.

Session 4- The Role of Law Enforcement in not Hindering Access by Prescribers and Dispensers, and by End-users, to Medical Opioids

Aims: Participants understand the importance of balancing medical opioid and MAT availability against diversion control.
Time: 90-120 mins
Resources: Slides, white board, butchers paper, marker pens
Handouts: Policing the diversion of medical opioids.

Slide 1 - Responsible control of medical opioids

- Balance must be achieved so that control does not restrict the prescription and subsequent consumption of necessary medical opioids
- The onus for striving towards an effective balance between medical opioid and MAT availability and diversion control, often rests with law enforcement authorities in particular

Trainer Notes: Responsible control is required to limit the diversion of medical opioids and MAT. However, balance must be achieved so that control does not restrict the prescription and subsequent consumption of necessary medical opioids. According to the Conventions, national policy should specify that opioids are indispensable, that governments must ensure adequate provision as well as diversion control, and must establish a competent authority to oversee implementation of Convention requirements. It is important to note that this authority is often connected with law enforcement. Therefore, the onus for striving towards an effective balance between medical opioid and MAT availability and diversion control, often rests with law enforcement authorities in particular.

Slide 2- Convention requirements

- individuals must be authorized to prescribe or dispense opioids by their professional license to practice, or be specially licensed to do so;
- movement of opioids may occur only between institutions or individuals so authorized under national law; and
- a medical prescription is required before opioids may be dispensed to a patient.

Trainer Notes: The Single Convention on Narcotic Drugs lays out three minimum criteria that countries must observe in developing national regulations regarding the dispensing of opioids (see slide). Beyond these requirements, specific domestic operational policies and practices are the responsibility of

member countries. This means that countries have considerable flexibility (as well as obligation) to apply reforms around unnecessarily restrictive drug control laws, regulations and practices to correct the medical opioid control and availability balance. (*This point is examined in greater detail in Session 6 for drug regulators*).

Slide 3 - Prescription fears

- Health professionals should be able to provide opiates without unnecessary fear of sanctions for unintended violations that may tend to inhibit prescribing or dispensing of opiates
- Policing of opioid prescription should accommodate physician decision making, so that access to medical opioids is an explicit goal of law enforcement practice, in balance with control of illegal use

Trainer Notes: The INCB has recommended that health professionals should be able to provide opiates without unnecessary fear of sanctions for unintended violations – including legal action for technical violations of the law – that may tend to inhibit prescribing or dispensing of opiates.

WHO guidelines stipulate that the policing of opioid prescription should be conducted with well informed sensitivity for the diversity and importance of discretion in physician decision making, ensuring that appropriate access to medical opioids is an explicit goal of law enforcement practice, in balance with control of illegal use.

Slide 4 – Restrictive regulations and procedures

- In practice, regulations relating to medical opioids (including MAT) often involve unnecessarily complex procedures which limit access to those who need them
- Excessive control measures mean that pharmacies and health providers do not stock opioids, that doctors do not prescribe opioids, and that opioid prescription processes are daunting.
- As a result, many people in legitimate need do not have adequate access

Trainer Notes: In practice, many countries have regulations relating to medical opioids (including MAT) that involve unnecessarily complex procedures which ultimately limit access to those who need them. For example, a recent review of medical opioid availability for cancer-related pain management in Europe found that regulatory restrictions to limit the accessibility of opioids were common, particularly in eastern European countries.

These control measures mean that pharmacies and health providers do not stock opioids, that doctors do not prescribe opioids because of the effort required or fear of liability, and that opioid prescription processes are so daunting that many of those in legitimate need do not have adequate access.

Slide 5 – Practice contradicting Convention requirements

Many country level regulations regarding opioid prescribing and dispensing contradict WHO and INCB recommendations. Examples include:

- requirements for patients to have a special permit,
- arbitrary dose limits,
- limitations on settings where opioids can be prescribed,
- restrictions on prescribing privileges to limited physician specialties,
- unwarranted restrictions on the number of days' supply that can be prescribed at one time,
- excessive limits on types of opioid dispensing sites
- and fear of legal sanctions among prescribers

The impact of such over-vigilant restrictions on patient care can be extreme

Trainer Notes: Examples of disproportionately restrictive regulation can be found in most jurisdictions where the implementation of unnecessarily complex licensing processes for healthcare institutions and health workers, and burdensome prescription procedures and prescription limitations, can impede access to adequate pain management and MAT. Fears of legal sanctions also contribute to the under-availability of essential medical opioids, including MAT.

The impact of such over-vigilant restrictions on patient care can be extreme. It is evident that "the science and best practices of opioids have progressed more rapidly than the legal structures governing them, leaving many antiquated and overly restrictive legal policies."

Slide 6-8 - Unintended impacts of diversion control

SLIDE 6

Fear of liability:

- Diversion control processes have tended to put pressure on the health sector by threatening prescribers and dispensers with potential legal sanctions, and this has resulted in the under-prescribing of essential opioids
- A study in the USA concluded that "Effective solutions to the conflicting public health crises of under-treated pain and prescription drug abuse will have to address the discordant perceptions between physicians and law enforcement."
- While countries are obliged to prevent inappropriate prescription of medical opioids, it is also important that regulators and law enforcement take a balanced approach in public messages to physicians and how they handle routine investigations of medical practice

Trainer Notes: This unintended impact is related to communications problems on the part of regulators, as well as to how law enforcement conducts its investigations. In most jurisdictions, diversion control processes have tended to put pressure on the health sector by threatening prescribers and dispensers with potential legal sanctions, and this has resulted in the under-prescribing of essential opioids.

In the United States, for example, doctors fear unjustified prosecution for prescribing opioids for pain and tend to react with excessive restraint in issuing opioid prescriptions. A 2008 study on prescribing offences in the United States found that, although convictions are relatively rare, mixed messages from regulators have resulted in fear among prescribers, undermining the treatment of pain. The study concluded that "Effective solutions to the conflicting public health crises of under-treated pain and prescription drug abuse will have to address the discordant perceptions between physicians and law enforcement."

While countries are obliged to prevent inappropriate prescription of medical opioids, it is also important that regulators and law enforcement take a balanced approach in public messages to physicians and how they handle routine investigations of medical practice.

Activity: 10 mins

Brainstorm with group what policies and procedures in place that they are aware of which might impact on access to opioids by prescribers.

SLIDE 7

Diversion sources

- The relative significance of different diversion sources is not well understood, and there is much concern about possible diversion mechanisms without indicating respective importance

- Some researchers have discovered extensive criminal diversion activities, suggesting that law enforcement diversion control efforts should be appropriately focused on these sources in the US, and that similar research should guide diversion control efforts in other regions

Trainer Notes: The relative significance of different diversion sources is not well understood. There is much concern about possible diversion mechanisms without indicating respective importance. For example, although sources of diversion of prescription opioids in the United States are not well known, the primary regulatory and law enforcement responses tend to be directed at patients, prescribers and manufacturers. However, some researchers have discovered extensive criminal diversion activities – including significant quantities of opioids stolen from distributors and pharmacies before the drugs are prescribed or dispensed – suggesting that law enforcement diversion control efforts should be appropriately focused on these sources in the US, and that similar research should guide diversion control efforts in other regions.

Slide 8 - Other unintended impacts of diversion control

- Other unintended impacts of diversion control can include stimulation of the illicit drug market and increased drug related harm
- Some countries have drug control laws and regulations with provisions that go beyond convention requirements, without necessarily preventing diversion
- In particular, overly stringent prescription requirements may lead to a situation where certain controlled drugs are more readily available on the unregulated market
- It is therefore recommended that diversion sources be scrutinized through a research process which identifies and prioritises key diversion sources for medical opioids

Trainer Notes: Other unintended impacts of diversion control can include stimulation of the illicit drug market and increased drug related harm. The INCB notes that some countries have drug control laws and regulations with provisions that go beyond convention requirements, without necessarily preventing diversion. In particular, overly stringent prescription requirements may lead to a situation where certain controlled drugs are more readily available on the unregulated market. Other negative impacts can include:

- increased crime as patients and/or drug dependent individuals turn to the illicit market to obtain pharmaceutical preparations, which are more expensive on the black market due to their scarcity;
- substitution of medical opioids with other drugs (i.e. alcohol, illicit drugs, or less effective over-the-counter analgesic medications that can result in

liver or gastro-intestinal toxicity) leading to other, potentially more severe, health issues;
- the creation of conditions favorable for increased heroin trade and/or diversion from the medical opioid supply.

It is therefore recommended that diversion sources be scrutinized through a research process which identifies and prioritises key diversion sources for medical opioids. From this information, balanced and proportionate control measures can be introduced with the aim of both limiting diversion and ensuring access for legitimate purposes.

This is discussed in more detail in Session Six -The Role of Law Enforcement in Ensuring a Safe Supply Chain for Medical Opiods.

Slide 9 - The law enforcement impact on access to MAT

- People participating in MAT programmes are frequently required to undergo mandatory urine testing, punitive dose reduction and discontinuation of treatment (involving withdrawal)
- Raids, arrests and harassment in or near MAT clinics have been reported in many countries
- In some jurisdictions, police threaten methadone patients with arrest or demand bribes
- People receiving MAT in community clinics often have their names and personal details added to government registries of drug users
- In some jurisdictions, police are not well informed about the legality of MAT and continue to make arrests in the vicinity of MAT clinics
- This highlights the need for law enforcement to adopt and implement policies, practices and ongoing education that support the medical treatment of drug users such that MAT can be more accessible to those requiring it

Trainer Notes: People participating in MAT programmes are frequently required to undergo mandatory urine testing, punitive dose reduction and discontinuation of treatment (involving withdrawal). Raids, arrests and harassment in or near MAT clinics have been reported in many countries including Malaysia, Kazakhstan, China, and Thailand. During 2007 in Odessa, Ukraine, patients in a MAT support group experienced ongoing harassment from law enforcement. In Kazakhstan, opposition from the Ministry of Interior has delayed the implementation of MAT programmes for years. In Kyrgyzstan, police threaten methadone patients with arrest or demand bribes.

People receiving MAT in community clinics often have their names and personal details added to government registries of drug users. For example, in Indonesia,

it is reported that police are not well informed about the legality of MAT (in this case, methadone) and continue to make arrests in the vicinity of MAT clinics. As a result, some MAT clients report that they have become targets for the police. This experience highlights the need for law enforcement to adopt and implement policies, practices and ongoing education that supports the medical treatment of drug users such that MAT can be more accessible to those requiring it.

Slide 10 - MAT regulations

- MAT entry protocol changes are crucial if treatment is to be accessible to those in need
- In some jurisdictions, MAT programme entry requirements are complicated and difficult to satisfy
- In many instances, MAT programme entry is controlled by law enforcement
- MAT regulations must be sufficiently straightforward and confidential, so as to make MAT accessible to those who stand to benefit from the therapy

Trainer Notes: MAT entry protocol changes are crucial if treatment is to be accessible to those in need. For example, until recently, China required that people using drugs undergo up to one year of detention in compulsory detoxification facilities or forced labour camps prior to entry into a methadone programme. Law enforcement often held the right to grant or deny admission into MAT programmes. Although these requirements were recently relaxed, some MAT clinics are yet to fully comply. For entry into MAT programmes, current Chinese guidelines stipulate four conditions, including that the person seeking MAT must:

1. pass through drug detoxification programmes multiple times;
2. be more than 20 years of age;
3. be a resident of the county, city or district where the treatment is provided (or have a temporary residence permit); and
4. exhibit 'civilised' behavior.

The age limit is waived if the person seeking MAT is HIV positive. Only those with residence permits issued by police are eligible – and these are routinely denied to migrants or others.

In Georgia, people seeking entry into MAT programmes must document that they have previously participated in a 'drug free' treatment programme. 'Drug free' treatment remains both expensive and scarce, and those individuals who undertake such treatment are added to government drug user registries, with the potential for harassment and discrimination.

MAT regulations must be sufficiently straightforward and confidential, so as to make MAT accessible to those who stand to benefit from the therapy.

Slide 11-17 - Important considerations towards developing diversion control regulations, policies and practices

SLIDE 11

- Law enforcement is generally bound by drug control regulations, which can be seen as restrictive by prescribers and dispensers
- WHO guidelines stipulate that the policing of opioid prescription should be conducted with well informed sensitivity for the diversity and importance of discretion in physician decision making, whilst ensuring that appropriate access to medical opioids is an explicit goal of law enforcement practice, in balance with the control of illegal use

Trainer Notes: Law enforcement is generally bound by drug control regulations, which can be seen as restrictive by prescribers and dispensers. WHO guidelines stipulate that the policing of opioid prescription should be conducted with well informed sensitivity for the diversity and importance of discretion in physician decision making, whilst ensuring that appropriate access to medical opioids is an explicit goal of law enforcement practice, in balance with the control of illegal use.

SLIDE 12

- *Article 38* of the Single Convention, paragraph 1 directs member states to give special attention to the treatment, education, rehabilitation, and social reintegration of people involved in illicit drug use
- Paragraphs 2 and 3 specify that there should be adequate training and education of personnel in order to achieve the objectives of paragraph 1

Trainer Notes: *Article 38* of the Single Convention, 'Measures against the Abuse of Drugs', provides some direction with regard to addressing drug abuse and its treatment. Paragraph 1 directs member states to give special attention to the treatment, education, rehabilitation, and social reintegration of people involved in illicit drug use, and paragraphs 2 and 3 specify that there should be adequate training and education of personnel in order to achieve the objectives of paragraph 1.

SLIDE 13

- However, even where facilitating policy and regulatory environment exists, cases of obstructive police activity are not unknown
- Policing needs to be consistent with regulatory reforms in order to control diversion, while supporting the expansion of medical opioid access

Trainer Notes: However, even where facilitating policy and regulatory environment exists, cases of obstructive police activity are not unknown. Policing needs to be consistent with regulatory reforms in order to control diversion, while supporting the expansion of medical opioid access.

Activity: (30-40 minutes).

Ask participants to read their handout – provided at the end of this Session.

Ask participants to break into groups of 5 to list problems faced in policing diversion of medical opioids in your country.

Unify groups and list problems (without repeats) on whiteboard.

List (on whiteboard) and discuss possible solutions with whole group.

SLIDE 14

- At the international level, diversion of opioid medications from the licit trade into illicit channels remains relatively rare and in small quantities compared to the necessarily large trade flow
- The goals of medical opioid diversion control programmes should be balanced to inform contextually specific strategies
- Research should guide diversion control efforts to be proportionate and relevant to the significance and characteristics of the source, thus promoting improved flow in end user access to opioid medications, including for MAT

Trainer Notes: It should be recalled that, at the international level, diversion of opioid medications from the licit trade into illicit channels remains relatively rare and in small quantities compared to the necessarily large trade flow.

Medical opioid diversion control programmes usually have three goals:

1. to limit access to those individuals with a legitimate need for the drug;
2. to identify and track instances where control over such legitimate access is compromised; and

3. to minimise the effect of controls upon legitimate medical practice.

These three goals should be balanced to inform contextually specific strategies.

Fear of diversion drives many jurisdictions' policies regarding medical opioids, and "a default position of limiting or precluding supply of prescription opioids for medical conditions appears to be the norm." This can result in restricted access to essential medications for many people in need.

SLIDE 15

"As long as fear of diversion exists, and no examination of the situation is made, it is likely that efforts to control diversion will be misdirected and lead to overly restrictive control of supply."

Trainer Notes: Diversion control measures are often instigated without an evidence base detailing key diversion sources. Once key diversion sources are identified, a more proportionate and efficient response can be implemented. Research should guide diversion control efforts to be proportionate and relevant to the significance and characteristics of the source, thus promoting improved flow in end user access to opioid medications, including for MAT. Measures which do not restrict, delay or interrupt legitimate access to opioid medications can then be implemented and evaluated.

SLIDE 16

- It is important that regulators and law enforcement understand the need for medical opioids, including MAT, and take a more balanced approach in public messages to physicians and how they handle routine investigations of medical practice

Trainer Notes: With regard to reducing misplaced stigma attached to the prescription and use of medical opioids, it is important that regulators and law enforcement learn and understand the need for medical opioids, including MAT, and take a more balanced approach in public messages to physicians and how they handle routine investigations of medical practice.

SLIDE 17

- Planning for medical opioid diversion prevention must be carefully considered and balanced against potential unintended consequences
- Laws and regulations must be tailored to the needs and responsibilities of all stakeholders, so as to ensure access without excessive restrictions or the deprivation of necessary treatment

Trainer Notes: Planning for medical opioid diversion prevention must be carefully considered and balanced against potential unintended consequences. Laws and regulations must be tailored to the needs and responsibilities of all stakeholders, so as to ensure access without excessive restrictions or the deprivation of necessary treatment. It is possible that significant increases in the availability of opioid pain medication will be accompanied by increased diversion of prescription opioids, but that these problems can be managed by a combination of provider training, patient education and regulatory oversight. The social benefits of better access to essential opioid medications clearly outweigh the costs.

Slide 18 - MAT specific guidance

- People accessing MAT programmes are among the most marginalised in society and, particularly when not in treatment, vulnerable to HIV transmission
- MAT has proved to be an essential component in an effective public health response and should therefore be unobstructed by any extraneous police activity
- There is a clear need for law enforcement to adopt and implement policies, practices and attitudes that support the medical treatment of drug users

Trainer Notes: People accessing MAT programmes are among the most marginalised in society and, particularly when not in treatment, vulnerable to HIV transmission. MAT has proved to be an essential component in an effective public health response and should therefore be unobstructed by any extraneous police activity. There is a clear need for law enforcement to adopt and implement policies, practices and attitudes that support the medical treatment of drug users.

- MAT regulations must be sufficiently straightforward and confidential, so as to make MAT accessible to those who stand to benefit from the therapy;
- Police should not routinely make arrests or question clients in or near MAT clinics or dispensing areas. This does not mean that police should not respond to reported criminal activity wherever it may occur – but does mean that police should not use MAT clinics to fill arrest quotas, or for over-patrolling;

- It is not a requirement of the Single Convention on Narcotic Drugs that police keep records on MAT clients. Police must not routinely keep records on MAT clients or access clinic records.

Handout – Policing the diversion of medical opioids.

An Australian study found that, from the perspective of law enforcement personnel, the policing of diverted medical opioid markets posed particular challenges. Key issues related to such policing include:

- the difficulties in distinguishing between illicitly and licitly held prescription pharmaceuticals (i.e. pharmaceutical identification);
- becoming aware of relevant scheduling and legislative considerations;
- developing an understanding of psychopharmacology of benzodiazepines and prescribed opioids, interactions with illicit drugs, and implications for behaviour;
- the apparent weaker relationship between prescription pharmaceutical use and crime than for illicit drugs; and
- similar policing responses were required regardless of whether intoxication is due to use of licit or illicit drugs.

A potential range of responses to the challenges associated with policing diverted medical opioid markets includes:

- the creation of alternatives to arrest and criminal charges, possibly through liaison with diversion programmes and service providers;
- decreasing the cost of drug treatments;
- a more holistic approach to the prescribing of drugs;
- the close monitoring of people who inject drugs who are prescribed central nervous system depressants;
- the development of alternative forms of buprenorphine that cannot be diverted;
- keeping police and doctors informed about prescribed drugs that are likely to be diverted;
- the education of doctors and pharmacists about the diversion of such drugs;
- encouraging the sharing of information between different bodies that produce data;
- peer education programmes built around demonstrating the harms associated with the intravenous administration of tablets;
- the distribution of pill and biological filters (used to 'filter out' non-soluble contents in pharmaceutical preparations) through needle and syringe programmes (NSP) in order to reduce health harms; and
- the establishment and maintenance of close relationships between the health and law enforcement sectors.

The development and relative priority of responses to be implemented should be informed through research to identify key diversion sources, and balanced against the relative significance of the source, and possible unintended consequences.

Session 5- The Role of Law Enforcement in Assisting Access by End-users to Medical Opioids

Aims: To understand the importance of partnership between law enforcement and civil society in improving access to medical opioids
Time: 90 mins
Resources: slides, white board, butchers paper, marker pens
Handouts: Examples of effective partnership between law enforcement and health agencies

Slide 1 - Working partnerships between law enforcement and health agencies

- The law enforcement sector playing a central role in medical opioid access reform with.
- For example, law enforcement agencies - working with public health authorities and with support from international community resources – have played a pivotal role in the process of policy reform to reduce legal barriers to pain relief in China
- The Ministry of Public Security authorised a process of assessment, policy reform and implementation that reduced the legal barriers to pain relief

Trainer Notes: Explain that police greatly influence the opioid supply chain, and can play a leading role in achieving improved balance between control and access to medical opioids.

Law enforcement agencies - working with public health authorities and with support from international community resources – have played a pivotal role in the process of policy reform to reduce legal barriers to pain relief in China. The Ministry of Public Security authorised a process of assessment, policy reform and implementation that reduced the legal barriers to pain relief.

Information was provided and workshops were held to address traditional negative attitudes towards opioid medications among government officials and delegates of legislature. Concepts such as drug tolerance and drug dependence were clarified, and exaggerated fears relating to opioid dependence have decreased. Reform changes encouraging improved opioid medication supply included:

- the Chinese Food and Drug Administration (FDA) became the central agency for production and distribution safety;
- simplified procedures for the production, pharmaceutical management and selling of medical opioids;
- relaxation of restrictions on production, storage, and shipment; and

- restructuring of prescription licensing procedures.

Substantial increases in consumption of medical morphine demonstrate the positive impact of the reform process in China.

This example is examined in more detail in the Session Six -The Role of Law Enforcement in Ensuring a Safe Supply Chain for Medical Opioids

Slides 2-4 - Partnerships between law enforcement and drug treatment (including MAT) providers

SLIDE 2

- In addition to not hindering access law enforcement can assist in optimizing access to, and benefits from, MAT
- Police collaboration with the health and NGO sectors frequently yields impressive results in addressing illicit drug related matters.

Trainer Notes: In addition to not hindering access law enforcement plays a central role in optimizing access to, and benefits from, MAT.

A systematic review of drug law enforcement evaluations examined a range of law enforcement approaches, including:

- international / national interventions (i.e. interdiction and drug seizure);
- reactive / directed interventions (including crackdowns and raids);
- partnership interventions (i.e. problem-oriented policing and community policing);
- individualised interventions (arrest referral); and
- interventions that used a combination of reactive / directed and partnership strategies.

Results indicated that "... proactive interventions involving partnerships between the police and third parties and/or community entities appear to be more effective at reducing both drug and non-drug problems in drug problem places than are reactive / directed approaches."

SLIDE 3

- Law enforcement can enhance the effectiveness of MAT by indirectly or directly facilitating access

- MAT is supported as an essential public health service by law enforcement through working partnerships with MAT (and other drug treatment) programmes in many countries
- Criminal behaviour, particularly for property and drug offences, progressively reduces the longer that an individual remains on MAT, and that offending is often high among those individuals who leave such treatment prematurely

Trainer Notes: Part of the basis for such law enforcement collaboration with the health and welfare sectors is the evidence demonstrating that criminal behaviour, particularly for property and drug offences, progressively reduces the longer that an individual remains on MAT, and that offending is often high among those individuals who leave such treatment prematurely.

Activity: (10 mins):

Give out Handout (Examples of effective partnership between law enforcement and health agencies).

Split group into groups of 4 and ask them to brainstorm the difficulties that might need to be addressed to foster collaboration between law enforcement agencies and NGO's who work in the drug use fields. When finished, ask each group to report back on their findings.

SLIDE 4

- Law enforcement and health workers should collaborate in order to ensure the effective delivery of MAT and pain management programmes
- To establish partnerships, law enforcement and the staff of MAT programmes need to create routine communication mechanisms to ensure regular dialogue on emerging challenges and issues

Ask: Do all participants agree that law enforcement and health workers should collaborate in order to ensure the effective delivery of MAT and pain management programmes? If there is disagreement, try to determine the reason and discuss as a larger group. Go back to facts and evidence regarding MAT from Session one, or proceed to the next slide and handout (addressing key police concerns).

Slide 5 - Police concerns about MAT

Police have sometimes raised concerns in relation to MAT programmes, including that:

- MAT programmes attract illicit drug users to the area
- MAT programmes attract drug users, causing increased levels of crime and public amenity problems
- Drug dealers target MAT programmes
- Police face difficulty dealing with public criticism of MAT programmes

Activity: (15 minutes)

Break group into 4 groups. Each group is given one of the above statements. Ask the groups to discuss how their specific concern might be addressed whilst at the same time, not restrict end-users right to access MAT. When finished, ask each group to report back on their findings

Trainer Notes: Refer to sensible responses to each concern as below.

MAT programmes attract illicit drug users to the area: It is important to remember that persons attending MAT programmes are illicit drug users who have opted to undertake legal treatment in an effort to solve problems associated with their illicit drug use. Generally, individuals attending clinics will live or work within the area – this is to facilitate access to, and compliance with, treatment.

At times, clients of MAT programmes may be involved in illegal activities. Balancing public order and public health concerns is not always easy, but MAT programmes are a public health strategy designed to reduce the aggregate harm of illicit drug use to the wider community.

MAT programmes attract drug users, causing increased levels of crime and public amenity problems: MAT programmes are generally established in response to treatment needs in a given location. Research shows that the presence of MAT clinics does not necessarily increase localised crime. If, however, police are concerned about illegal activity – particularly drug dealing – in the vicinity of MAT sites, they should seek to resolve this through liaison with the manager of the MAT programme.

Drug dealers target MAT programmes: MAT clinics are not off limits to police. If the supply of drugs and/or other criminal behaviour is occurring in the vicinity of a MAT site, police should take appropriate action. However, where possible, police should consider liaising with the management of the MAT programme beforehand.

How can police deal with public criticism of MAT programmes? Police often feel caught in the middle of the wide range of community opinions

regarding MAT programmes. It can be helpful if police officers are familiar with the evidence supporting MAT.

Slide 6 – Building bridges with MAT and pain management providers

Information that may be useful for law enforcement and the staff of MAT programmes to share can include:

- review of the public health objectives and proven benefits of MAT and of pain relief programmes
- ground rules regarding information sharing, which comply with the codes of ethics and objectives of both services (i.e. respecting confidentiality);
- specific information about the roles of the staff involved in the medical opioid or MAT programme
- the location of pain management clinics and MAT dosing sites;
- the hours of operation of pain management and MAT services;
- the identification of main contact persons within law enforcement and the MAT programmes or pain management clinic.

Trainer Notes: Explain that this list presents some practical starting points for forming functional working relationships between police and MAT clinics or pain management clinics.

Slides 7-9 - Pre-arrest referral of people who use drugs illicitly to health and welfare groups

SLIDE 7

- Working partnerships between law enforcement and drug treatment (including MAT providers) are becoming an increasingly legitimate category of law enforcement intervention through diversion schemes
- Diversion programmes are generally conducted by police and/or require police input
- Diversion programmes aim to prevent first offenders from entering the criminal justice system
- Offenders who have previously been apprehended can also be encouraged to enter a treatment programme in order to reduce their illicit drug use and associated criminal activity

Trainer Notes: Working partnerships between law enforcement and drug treatment (including MAT providers) are becoming an increasingly legitimate category of law enforcement intervention through caution and arrest referral (i.e.

diversion) schemes. These approaches are supported by the UN Drug Conventions and the United Nations system. (*See, for example, the 2007 report of the INCB on proportionality in dealing with drug-related offences: http://www.incb.org/pdf/annual-report/2007/en/chapter-01.pdf*).

Diversion programmes are generally conducted by police and/or require police input. Diversion strategies examined in this session focus on pre-arrest and pre-court strategies. Police are most involved in pre-arrest and pre-trial diversion strategies, although they can have a role in other forms of diversion.

Diversion or referral programmes aim to prevent first offenders who are unlikely to re-offend from entering the criminal justice system. Once someone has entered the criminal justice system, the effects of incarceration and of having a criminal record can be far-reaching and generate long-lasting impediments. Offenders who have previously been apprehended can also benefit from referral, if encouraged to enter a treatment programme in order to reduce their illicit drug use and associated criminal activity.

SLIDE 7

- In India, regular training on drug use and treatment by the Calcutta Samaritans to law enforcement.
- Informal arrangement involving first time drug offenders being referred for drug treatment, rather than being directed into the criminal justice system.
- Law enforcement is actively involved with the NGOs.
- Reinforces positive perceptions of harm reduction approaches, including MAT, by law enforcement and the broader community.

In India, the Calcutta Samaritans deliver regular sensitisation workshops to law enforcement on the subject of drug use and drug treatment. The result of this ongoing collaboration includes an informal arrangement which involves first time drug offenders being referred for drug treatment, rather than being directed into the criminal justice system. Law enforcement is actively involved with the NGOs, with at least one officer in each police station sufficiently motivated and aware of the present drug use scenario (and associated issues). Experience has helped to reinforce positive perceptions of harm reduction approaches, including MAT, as law enforcement and the broader community have observed the encouraging outcomes of such interventions.

SLIDE 8

- Pre-arrest diversion can occur when police notice a minor offence (such as the simple non-violent possession of illicit drugs) but have not made an arrest – methods range from informal warnings through to deferred sentencing
- Verbal warnings can involve taking the person home or instructing them to move from the place where the problem occurred

Trainer Notes: Pre-arrest diversion can occur when police notice a minor offence (such as the simple non-violent possession of illicit drugs) but have not made an arrest. Methods range from informal warnings through to deferred sentencing.

Verbal warnings can involve taking the person home or instructing them to move from the place where the problem occurred. Warnings present an excellent opportunity to provide information regarding MAT and other drug treatment and harm reduction material.

SLIDE 9

Cautioning schemes can include referral to education and/or drug treatment (including MAT)

- The Cannabis Cautioning Scheme of New South Wales (NSW) provides for formal cautioning of adult offenders detected for minor cannabis offences, with the aim of using police intervention to assist offenders to consider the legal and health ramifications of their cannabis use and seek treatment and support

Trainer Notes: Cautioning schemes can include referral to education and/or drug treatment (including MAT). The process generally involves following set procedures and some record keeping. For example, a 'cannabis cautioning' scheme is where a person who is apprehended for the possession or use of a small amount of cannabis is not charged but is instead given a 'caution notice' with some accompanying health information. At police discretion, the offender is offered the option of a caution, provided that the offender admits to the offence. A person can accumulate two cautions only, and a subsequent offence will result in prosecution. Usually in such a scheme the person's name is recorded for future reference, but the person has been diverted from the criminal justice system. Cannabis educational information and a referral for a cannabis education session accompany such a caution.

Slides 10- 15 - Post arrest referral of non-violent drug offenders to drug treatment

SLIDE 10

- Referral after arrest (including drug courts, bail conditions and deferred sentencing) also targets non-violent illicit drug users, aiming to redirect them into non-incarceration alternatives such as treatment
- There should be sufficient admissible evidence that the offender is using or in possession of a small (i.e. non-trafficable) quantity of illicit drugs, and that the drugs must be for personal use only
- Evaluations of arrest referral programmes indicate post-arrest reductions in drug use
- Partnership approaches between local level law enforcement agencies and community service providers (including MAT clinics) can bring benefits, in terms of crime reduction, cost-effectiveness and positive public health outcomes.

Trainer Notes: Referral after arrest (including drug courts, bail conditions and deferred sentencing) also targets non-violent illicit drug users, aiming to redirect them into non-incarceration alternatives such as treatment. There must usually be sufficient admissible evidence that the offender is using or in possession of a small (i.e. non-trafficable) quantity of illicit drugs, and that the drugs must be for personal use only.

SLIDE 11

National Drug Interventions Programme, United Kingdom

High crime areas in England and Wales:

- People arrested for certain drug related offences are tested upon arrest for illicit drug use. If such individuals test positive, drug assessment performed which may then result in referral to treatment. Most of those referred to drug dependence treatment demonstrate reduced involvement in property crime.

In lower crime areas:

- Referral programmes without drug testing to divert people into appropriate treatment. Evaluations of arrest referral programmes indicate post-arrest reductions in drug use.

Trainer Notes: In the United Kingdom, the national Drug Interventions Programme, seeks to address the problem of drug-related offending by encouraging drug using offenders to access treatment (including MAT). In high crime areas in England and Wales, people who are arrested for certain drug related offences are tested upon arrest or charge for illicit drug use. If such

individuals test positive, an assessment of their drug use is undertaken which may then result in referral to treatment. Most of those referred into drug dependence treatment demonstrate reduced involvement in property crime. In lower crime areas, arrest referral programmes without drug testing are used in order to divert people who use drugs into appropriate treatment. Evaluations of arrest referral programmes indicate post-arrest reductions in drug use.

An ongoing law enforcement operation in Brighton (United Kingdom), named 'Operation Reduction,' has been subject to an independent evaluation. Law enforcement personnel, working alongside treatment providers, offer people using drugs who are funding their drug use via drug sales a fast-track route into treatment. The evaluation of this operation found it was well received by stakeholders, with reductions in criminal activity at both district and individual levels. Cost benefits were also demonstrated, with estimates that for every £1 spent on the operation, £3 was saved on crime costs.

These examples show how effective the development of partnership approaches between local level law enforcement agencies and community service providers (including MAT clinics) can be, in terms of crime reduction, cost-effectiveness and positive public health outcomes.

SLIDE 12

Drug Courts.

- Drug courts are alternative courts that handle the cases of non-violent drug using offenders under the justice system, generally diverting offenders towards assistance, including MAT
- Drug courts involve intersectoral collaboration where judiciary, law enforcement, social services, and treatment communities work together to assist non-violent offenders outside a prison context.
- Graduates of drug courts are less likely to be rearrested than persons processed through traditional courts
- Findings from drug court evaluations show that participation in drug courts results in fewer re-arrests and reconvictions, or longer periods between arrests
- The role of law enforcement in drug courts is significant, and the benefits for all sectors and the public are also significant.

Trainer Notes: In many jurisdictions, the trend towards the use of drug courts emerged from the reality that addressing illicit drug use through law enforcement mechanisms would continue to pose disproportionate challenges for the criminal court system. For example, in the US in 2004, 53% of persons in state prison were identified with a drug dependence or abuse problem, but only

15% were receiving professional treatment. Drug-related crime continues to present a burden to society, one that punitive 'zero tolerance' enforcement efforts alone have failed to curb.

The role of law enforcement in drug courts is significant. A survey of US law enforcement officers involved in drug court work was conducted in 2000, in which respondents outlined their potential duties to include:

- discussing possible drug court participation with offenders at the time of their arrest;
- referring cases of potentially eligible defendants to drug court staff;
- attending drug court hearings;
- assisting with participant supervision;
- serving on drug court oversight committees; and
- attending drug court graduations.

The same survey asked law enforcement respondents to indicate the impact that the drug court has had upon police capability to respond to criminal activity or otherwise carry out functions. The most frequently cited impact related to the new relationships that the programme had generated between law enforcement and other justice system and community agencies, including greater interaction with local substance dependency treatment service providers and community groups. Other frequently cited impacts related to the availability of a more effective response to arrests of illicit drug users.

SLIDE 13

- Some drug court programmes include referral for assessment and treatment as a condition of bail
- A report on improving the quality of drug courts found that drug court programmes should be flexible enough to allow the appropriate use of the range of medications that have been shown to be useful in the treatment of opioid dependence
- MAT medications such as methadone and buprenorphine have been clearly shown to improve treatment outcomes for drug dependent individuals, and the data fully justify the conclusion that MAT should be considered as an integral part of any drug court treatment programme
- Further, the cost-effectiveness of the use of medications in preventing re-incarceration more than offsets the additional costs of providing medications.

Trainer Notes: Some drug court programmes include referral for assessment and treatment as a condition of bail. For example, in the State of Victoria, Australia, police run the 'Court Referral Education, Drug Intervention and Treatment (CREDIT)' programme. The CREDIT programme can be offered to offenders with substance use issues as part of bail proceedings after initial arrest. Persons charged with any offence who have an immediately presenting drug problem are referred by police for assessment by a drug clinician based at the court and, where appropriate, the alleged offender is diverted into a recommended treatment regime by the magistrate as a condition of bail. However, this option is only available at Magistrates' Courts where there is a court-appointed drug clinician.

SLIDE 14

- Drug court programmes should allow appropriate use of the range of medications that have been shown to be useful in the treatment of opioid dependence.
- MAT medications such as methadone and buprenorphine should be considered as an integral part of any drug court treatment programme.
- Evaluations of the net costs and benefits of drug courts across the US show that drug courts save money compared to simple probation and/or incarceration, primarily due to reductions in arrests, case processing, jail occupancy, and victimisation costs.

Trainer Notes: Drug court programmes should be flexible enough to allow the appropriate use of the range of medications that have been shown to be useful in the treatment of opioid dependence. MAT medications such as methadone and buprenorphine have been clearly shown to improve treatment outcomes for drug dependent individuals, and the data fully justify the conclusion that MAT should be considered as an integral part of any drug court treatment programme. To deny drug court participants the option of receiving medications for their treatment is in our opinion unethical.

Further, the cost-effectiveness of the use of medications in preventing re-incarceration more than offsets the additional costs of providing medications. Evaluations of the net costs and benefits of drug courts across the US show that drug courts save money compared to simple probation and/or incarceration, primarily due to reductions in arrests, case processing, jail occupancy, and victimisation costs.

SLIDE 15

- Another potential diversion method is via **deferred sentencing,** which targets persons who are drug dependent and have been found guilty of an offence
- Sentencing can be deferred for a set period with a specific condition to attend drug treatment
- Pre-sentence clinical drug assessments are undertaken and a treatment plan is recommended to the court
- Offenders then attend the prescribed drug treatment and a report on progress is made to the court prior to sentencing

Trainer Notes: Another potential diversion method is via deferred sentencing, which targets persons who are drug dependent and have been found guilty of an offence. Sentencing can be deferred for a set period with a specific condition to attend drug treatment. Pre-sentence clinical drug assessments are undertaken and a treatment plan is recommended to the court. Offenders then attend the prescribed drug treatment and a report on progress is made to the court prior to sentencing.

Slide 16 - Guidance points

- Arrest and court referral schemes are effective in moving dependent drug users towards social reintegration
- Law enforcement agencies should put greater emphasis on referral to treatment
- Three key approaches which can be used by law enforcement to enhance access to MAT include referring to drug treatment, more formal diversion (such as caution schemes and drug courts) and the use of discretion in policing around MAT dispensing sites
- Law enforcement plays a vital role in ensuring improved access to medical opioids and MAT –through regulatory reform, developing partnerships with community health providers, the balanced application of police discretion, and a range of formal and informal diversion methods

Drug control regulators within home affairs or public security ministries can springboard reforms to establish a better balance between law enforcement concerns and more streamlined access to opioid medicines for those in need.

Arrest and court referral schemes are effective in moving dependent drug users towards social reintegration. Law enforcement agencies should put greater emphasis on referral to treatment, rather than on the more resource-intensive process of prosecution and imprisonment.

Three key approaches can be used by law enforcement to enhance access to MAT:

1. referring – informally or formally encouraging people who use drugs to enter treatment through the provision of advice;
2. more formal diversion from the criminal justice system (including caution schemes and drug courts); and
3. use of discretion in policing around MAT dispensing sites.

In order to effectively implement such reforms, changes in police attitude and practice may be required. These can be shaped by an awareness of the benefits of MAT, including those of relevance to law enforcement (i.e. those related to cost-effectiveness and reduced criminal activity) and a working understanding of methods which police can employ to facilitate access to MAT.

This session examining referral and diversion into treatment (including MAT) highlights that law enforcement plays a vital role, expressed through regulatory reform, developing partnerships with community health providers, the balanced application of police discretion, and a range of formal and informal diversion methods. Through knowledge of the key concepts, experience and evidence detailed in this guidance tool and accompanying training, law enforcement implementers will understand the rationale and methods needed to ensure more efficient policing of, as well as more streamlined access to, essential medical opioids and MAT.

Handout - Examples of effective partnership between law enforcement and health agencies

Kolkata, India Case History

One example of successful collaboration between law enforcement and the health and welfare sectors is found in Kolkata, India. Drug law enforcement in India is bound by the Narcotic Drug and Psychotropic Substance Act of 1985. However, the police in Kolkata have adapted drug control programmes to reflect current needs. Further, law enforcement in Kolkata are well informed regarding harm reduction due to close ties and working relationships with several NGOs operating in drug use fields. The Society for Community Intervention and Research (SCIR), with the assistance of Sharan Society for Service to Urban Poverty, established two drop-in centres for people who inject drugs, during the late 1990s. In 1999, a three year trial MAT programme was implemented via these drop-in centres. The smaller of the two drop-in centres is located directly beside a police station. Collaboration with the Kolkata Police (North Division), including patronage by the Kolkata Deputy Commissioner of Police, has ensured that law enforcement and health and welfare efforts are complimentary, to the point that the police stationed there frequently make tea for, and occasionally supply food to, SCIR staff and those people using drugs accessing the drop-in centre.

Cautioning Scheme, NSW Australia

A working example can be found in the Cannabis Cautioning Scheme of New South Wales (NSW) which provides for formal cautioning of adult offenders detected for minor cannabis offences, with the aim of using police intervention to assist offenders to consider the legal and health ramifications of their cannabis use and seek treatment and support. Under this scheme, adults detected by police using or in possession of not more than 15 grams of dried cannabis and/or equipment for using the cannabis may receive a formal police caution, rather than face criminal charges and court proceedings. The Scheme only applies to adults and allows police to exercise their discretion in appropriate cases and issue a caution. Police are still able to decide to formally charge offenders. A person can only be cautioned twice and cannot be cautioned at all if they have prior convictions for drug offences or offences involving violence or sexual assault. The Scheme also does not apply to those caught supplying cannabis, and drug dealers continue to be arrested and prosecuted. The formal police caution warns of the health and legal consequences of cannabis use and provides each cautioned person with information about treatment and support services. In particular, the caution notice advises offenders that they can call the

Alcohol and Drug Information Service (ADIS) for confidential help and information regarding their cannabis use. Persons who receive a second, final, caution are required to contact the ADIS for a mandatory education session about their cannabis use.

Drug Interventions Programme, UK

In the United Kingdom, an example is found in the national Drug Interventions Programme, which seeks to address the problem of drug-related offending by encouraging drug using offenders to access treatment (including MAT). In high crime areas in England and Wales, people who are arrested for certain drug related offences are tested upon arrest or charge for illicit drug use. If such individuals test positive, an assessment of their drug use is undertaken which may then result in referral to treatment. Most of those referred into drug dependence treatment demonstrate reduced involvement in property crime. In lower crime areas, arrest referral programmes without drug testing are used in order to divert people who use drugs into appropriate treatment. Evaluations of arrest referral programmes indicate post-arrest reductions in drug use.

Operation Reduction, UK

An ongoing law enforcement operation in Brighton (United Kingdom), named 'Operation Reduction,' has been subject to an independent evaluation. Law enforcement personnel, working alongside treatment providers, offer people using drugs who are funding their drug use via drug sales a fast-track route into treatment. The evaluation of this operation found it was well received by stakeholders, with reductions in criminal activity at both district and individual levels. Cost benefits were also demonstrated, with estimates that for every £1 spent on the operation, £3 was saved on crime costs.

Session 6- The Role of Law Enforcement in Ensuring a Safe Supply Chain for Medical Opioids

An additional Session for drug regulators and higher level (policy making) law enforcement participants

Aims: Participants are aware of specific control regulations as specified in conventions.
Time: 2 hours
Resources: Slides, a small package to use in the "Control to Ensure Availability' Activity, white board, butchers paper, marker pens

Slide 1

The Convention on Psychotropic Substances of 1971 encourages member states, where necessary, to educate ***regulators*** *and health-care professionals, including through targeted awareness-raising campaigns, to recognize that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes.*

Slides 2-7 - Summary of Drug Convention requirements

SLIDE 2

- The Conventions aim to prevent diversion of narcotic drugs, while at the same time ensuring their availability for legitimate purposes.
- The Convention specifies control measures and provisions over:
  - Cultivation of plants that produce narcotic drugs
  - production, manufacture, trade, and distribution of narcotic drugs
  - medical treatment and rehabilitation of drug dependent individuals
- The 'Competent Authority" –authorised to estimate medical requirements, manage import and export licenses, report required statistics, and supervise adequate controls over distribution – is often supervised by agencies that are part of law enforcement.
- The INCB has stated that diversion of opioid medications at the international level, from the licit trade into illicit channels, remains relatively rare and in small quantities compared to the large trade flow

Trainer Notes: The Convention system is intended to ensure medical opioid availability and prevent diversion.

It includes control measures over the cultivation of plants that serve as sources of raw material of narcotic drugs, provisions regarding the obligations of national authorities in the application of control measures over the production, manufacture, trade, and distribution of narcotic drugs, as well as provisions for the medical treatment and rehabilitation of addicts."

The Convention system is inter-related with narcotic drugs law enforcement and regulatory frameworks at country level. For example, parties are required to nominate a Competent Authority which is authorized to estimate medical requirements, manage import and export licenses, report required statistics, and supervise adequate controls over distribution. In some countries, the Competent Authority is supervised by agencies that are part of law enforcement.

In discussion regarding export and import requirements, it is noteworthy that the INCB has stated that diversion of opioid medications at the international level, from the licit trade into illicit channels, remains relatively rare and in small quantities compared to the large trade flow.

Activity: (10 minutes)

Ask participants to describe the relationship between the Competent Authority and law enforcement in their country.

Trainer Notes: Write these relationships on butcher paper

SLIDE 3

Operational requirements of control for import and export are:

- providing details of the competent authority to the INCB;
- licenses for import and separate authorisation for each import;
- importing only from INCB authorised countries;
- providing detailed import certificates to the competent authority of the export country to secure export authorisation;
- having the export certificate referencing the import certificate together with the export and a copy is provided to the importing country;
- specifying the amount actually exported on the export authorization;

- recording completion and amount of each import and reporting this to the exporting country; and,
- quarterly documentation of all imports and exports for the INCB.

Trainer Notes: As most countries do not cultivate opium poppy plants, the importation of opioids is the first – and most stringently controlled – step in the medical opioid supply chain. Operational requirements of control for import and export involve:

- providing details of the competent authority to the INCB;
- licenses for import and separate authorisation for each import;
- importing only from INCB authorised countries;
- providing detailed import certificates to the competent authority of the export country to secure export authorisation;
- having the export certificate referencing the import certificate together with the export and a copy is provided to the importing country;
- specifying the amount actually exported on the export authorization;
- recording completion and amount of each import and reporting this to the exporting country; and, quarterly documentation of all imports and exports for the INCB

SLIDE 4

- Although the import regulation requirements set forth in the Single Convention have been effective in preventing diversion from international trade, regulatory requirements do pose challenges at national level where the process can cause supply delays
- Countries committed to ensuring adequate availability of medical opioids and MAT can avoid such delays by establishing an effective streamlined system and running checks to ensure that no blockages occur

Trainer Notes: In practice, the import regulation requirements set forth in the Single Convention have been effective in preventing diversion from international trade. However, the regulatory requirements do pose challenges at national level where the process can cause supply delays. Countries committed to ensuring adequate availability of medical opioids and MAT, including resource constrained countries, can avoid such delays by establishing an effective streamlined system and running checks to ensure that no blockages occur.

We will examine other specifications and definitions set forth in the Conventions, and discuss how countries can work within the specifications to better ensure an efficient opioid supply chain without compromising control obligations.

SLIDE 5

Cultivation:

- *Article 23* of the Single Convention specifies that member countries applying to cultivate poppy plants for opium production must establish one or more government opium agencies to oversee set requirements relating to designated growing areas, cultivator licensing harvesting and trade
- *Article 24* of the Single Convention requires that countries notify the INCB if planning to initiate or increase poppy cultivation for the purposes of opium production
- *Article 29* of the Single Convention specifies that member countries must license manufacturers with periodical permits and ensure that excess accumulation does not occur

Trainer Notes: Cultivation: The Single Convention on Narcotic Drugs specifies that member countries applying to cultivate poppy plants for opium production must establish one or more government opium agencies to oversee set requirements relating to designated growing areas, cultivator licensing harvesting and trade (*Article 23*). The Convention also requires that countries notify the INCB if planning to initiate or increase poppy cultivation for the purposes of opium production. Planning for increases in opium production must account for prevailing world need for opium, so that the production of opium does not result in over-production. If production is likely to result in illicit trafficking, production should not occur (*Article 24*).

Activity: (5-10 minutes)

If participants are from a country which cultivates poppy plants, discuss how Convention requirements are applied. Do the cultivation regulations go beyond the specified controls? Discuss.

Note: Write key themes/points on butcher paper

SLIDE 6

Manufacture:

- Drug 'manufacture' means all processes, other than production, by which opioids may be obtained and includes refining as well as the transformation of poppy products into other opioid medications
- Drug 'production' refers to the separation of opium from poppy plants
- Member countries must license manufacturers with periodical permits and ensure that excess accumulation does not occur (*Article 29*). The Convention also requires countries to refrain from producing opium or manufacturing opioids if doing so may result in illicit traffic.

Trainer Notes: These definitions are important for countries engaged in making opioid medications. According to the Single Convention on Narcotic Drugs, drug manufacture and production are defined as follows: (see slide).

Activity: (10 minutes)

If participants are from a country which manufactures opioid medicines, discuss how Convention requirements are applied. Do the regulations go beyond the specified controls? Discuss.

Note: Write key themes/points on butcher paper

SLIDE 7

Storage and transport:

- Monitoring and control of domestic storage and transport of opioid poppy products is not detailed in the Convention, so designated government opium agencies are required to devise their own systems
- However, at every stage of the supply chain, *Article 33* of the Single Convention applies: "The Parties shall not permit the possession of drugs except under legal authority"

Trainer Notes: Storage and transport: Monitoring and control of domestic storage and transport of opioid poppy products is not detailed in the Convention, so designated government opium agencies are required to devise their own systems. However, at every stage of the supply chain, *Article 33* on possession of drugs applies: "The Parties shall not permit the possession of drugs except under legal authority."

Activity: (10-15 minutes)

Discuss how Convention requirements for storage and transport of opioid medicines and MAT are applied. Do the regulations go beyond the specified controls? In what way? Discuss.

Trainer Notes: Write key themes/points on butcher paper

SLIDE 8

Dispensing and administration:

- Provisions of the Single Convention regulating dispensing and administration of opioids involve relatively straightforward licensing and medical prescription safeguards
- Countries have considerable flexibility (as well as obligation) to apply reforms around unnecessarily restrictive drug control laws, regulations and practices to correct the medical opioid control and availability balance

Trainer Notes: Dispensing and administration: Beyond the specifications summarised above, specific domestic operational policies and practices connected with licit opioid production are the responsibility of member countries. This means that countries have considerable flexibility (as well as obligation) to apply reforms around unnecessarily restrictive drug control laws, regulations and practices to correct the medical opioid control and availability balance.

Activity: (10-15 minutes)

Discuss how Convention requirements for dispensing and administration of opioid medicines and MAT are applied. Do the regulations go beyond the specified controls? In what way? Discuss.

Note: Write key themes/points on butcher paper

Slides 9-15 - Preventing diversion of opioids

SLIDE 9

- As with all controlled medications, opioid MAT and pain medications carry the potential for diversion
- Effective diversion control is an important element in providing safe access to medical opioids and MAT
- The relative significance of different diversion sources is not well understood
- Fears of diversion drive many jurisdictions' policies regarding medical opioids, and this can result in restricted access to essential medications for many people in need
- Further, this sometimes fear driven approach also appears unsuccessful in avoiding diversion

Trainer Notes: Diversion is here understood to refer to "the unsanctioned supply of regulated pharmaceuticals from legal sources to the illicit drug market, or to a user for whom the drugs were not intended." As with all controlled medications, opioid MAT and pain medications carry the potential for diversion. Diversion can occur at any point along the chain from wholesale to consumer.

The relative significance of different diversion sources is not well understood. Many discussions refer to possible diversion mechanisms without indicating respective significance.

For example, although sources of diversion of prescription opioids in the US are not well-known, the primary regulatory and law enforcement responses tend to be directed at patients and prescribers. However, some recent data indicates a significant number of thefts of medical opioids from distributors and pharmacies, suggesting that diversion control efforts should be appropriately focused on these sources in the United States, and that similar research should guide diversion control efforts in other regions.

It is evident that fears of diversion drive many jurisdictions' policies regarding medical opioids, and "a default position of limiting or precluding supply of prescription opioids for medical conditions appears to be the norm." This can result in restricted access to essential medications for many people in need.

Further, this approach also appears unsuccessful in avoiding diversion. Even in countries with a primary focus on diversion control, the measures appear to be not only unsuccessful in completely avoiding diversion, but also to contribute to growing epidemics of opioid injecting and HIV transmission, while choking off legitimate patient access.

SLIDE 10

"As long as fear of diversion exists, and no examination of the situation is made, it is likely that efforts to control diversion will be misdirected and lead to overly restrictive control of supply."

Trainer Notes: Diversion control measures are often instigated without an evidence base detailing key diversion sources.

Activity: (15 minutes)

Break into smaller groups and ask what steps a country will need to take to ensure that control diversion is well focused.

With the main group, discuss in general terms (without fault finding or laying blame) whether existing diversion control underwent these steps.

SLIDE 11

- From the perspective of law enforcement personnel, the policing of diverted medical opioid markets poses particular challenges
- A range of responses to the challenges associated with policing diverted medical opioid markets have been developed
- It is recommended that planning for medical opioid diversion prevention be carefully researched, considered and balanced versus potential unintended consequences

Trainer Notes: Medical opioid diversion control programmes usually have three goals, including:

1. to limit access to those individuals with a legitimate need for the drug;
2. to identify and track instances where control over such legitimate access is compromised; and
3. to minimise the effect of controls upon legitimate medical practice.

These three goals should be utilised in order to generate contextually specific strategies.

SLIDE 12

Unintended consequences:

Of particular note, it is recommended that planning for medical opioid diversion prevention be carefully considered and balanced versus potential unintended consequences, such as:

- increased crime as patients and/or drug dependent individuals turn to the illicit market to obtain pharmaceutical preparations, which are more expensive on the black market due to their scarcity;
- substitution of medical opioids with other drugs (i.e. alcohol, illicit drugs, or less effective over-the-counter analgesic medications that can result in liver or gastro-intestinal toxicity) leading to other, potentially more severe, health issues;
- the creation of conditions favorable for increased heroin trade and/or diversion from the medical opioid supply.

Other unintended impacts of diversion control can include stimulation of the illicit drug market and increased drug related harm. The INCB notes that some countries have drug control laws and regulations with provisions that go beyond convention requirements, without necessarily preventing diversion. In particular, overly stringent prescription requirements may lead to a situation where certain controlled drugs are more readily available on the unregulated market.

SLIDE 13

Unintended impacts of diversion control: Prescription monitoring

- In several countries that have introduced the 'triple prescriptions' system as part of their approach to controlling the diversion of medical opioids, the result has been restricted prescribing to patients requiring pain management medications
- PMPs are not intended to interfere with appropriate medical practice
- There has been little research to examine the impact of PMPs on physician prescribing, pain management or drug diversion

Trainer Notes: While the Single Convention (Article 30 – 2(b)(ii)) states that countries may consider requiring official prescription forms in 'counterfoil books' for opioid prescriptions, in several countries that have introduced the 'triple prescriptions' system as part of their approach to controlling the diversion of medical opioids, this has restricted prescribing to patients requiring pain management medications. In most European countries, for example, difficulty in accessing the required prescription is common, and in some countries, physicians need to purchase the prescription forms.

The United States (US) Drug Enforcement Administration (DEA) has declared, without supporting data, that prescribing and dispensing accounted for the

majority of prescription opioids diverted to the black market in the United States, while other US law enforcement and regulatory agents believe that the major diversion mechanism is 'doctor shopping' (where an individual 'shops' from doctor to doctor, acquiring multiple prescriptions for prescription medications) and pharmacy theft or forgery. Prescription monitoring programmes (PMPs) have been introduced in some American states to prevent and detect the diversion of controlled substances. PMPs are not intended to interfere with appropriate medical practice. However, clinicians' concerns about increased regulatory scrutiny could lead to a reduction in opioid use and, therefore, less than optimal pain control. Further, there has been little research to examine the impact of PMPs on physician prescribing, pain management or drug diversion.

SLIDE 14

Unintended impacts of diversion control: Prescription monitoring

PMPs should not be administered by law enforcement agencies, but rather should be seen as public health intervention tools. Guidelines in operating prescription monitoring include:

- protecting patient confidentiality;
- assuring individual healthcare professionals access to monitoring data about their individual patients, so that they can evaluate those patients' use of controlled substances;
- allowing law enforcement agencies access to the data, but only when probable cause justifies such access in the course of investigating possible abuse or diversion;
- developing educational programmes to minimise concerns about regulatory scrutiny when prescribing or dispensing controlled substances as part of legitimate medical practice.

SLIDE 15

- Ensuring that such potential unintended consequences are suitably addressed, without excessive restrictions or the deprivation of necessary treatment, is a challenge
- The scope of law enforcement responses to illicit markets for medical opioids need not be limited to supply reduction initiatives alone
- Responsible control is required to limit diversion and resulting harms such as overdose, but the balance must be adjusted to ensure that control does not restrict access to legitimate prescription of necessary opioid medications

Trainer Notes: Ensuring that such potential unintended consequences are suitably addressed remains a challenge. There has been little research into this area to date, and there seem to be few cases where national policies spanning palliative care, HIV, MAT, and other pain management have been produced.

It is apparent that the scope of law enforcement responses to illicit markets for medical opioids need not be limited to supply reduction initiatives alone. A broader range of law enforcement responses reinforces the diverse, constructive and complementary roles that law enforcement may play with regards to both demand and harm reduction, and other strategies that aim to reduce mortality and morbidity associated with drug use.

Some degree of responsible control is required to limit diversion and resulting harms such as overdose, but the balance must be adjusted to ensure that control does not restrict access to legitimate prescription of necessary opioid medications.

Slide 16 - Terminology

- Drugs of addiction
- Dangerous drugs
- Poisons

Trainer Notes: Finally, a review of terminology used by drug regulators is recommended. Several countries use stigmatizing terms for opioid analgesics (such as 'drugs of addiction', 'dangerous drugs' or 'poisons') in the regulations controlling their prescription and dispensation.

Activity: (10 minutes)

Ask participants why these sorts of terms may be stigmatizing and what non-stigmatising terminology can be used to replace them.

Slide 17 - Control to ensure availability

- Most countries have tended to over-emphasise control at the expense of access, thus impeding the Single Convention's mandate and causing unnecessary pain and suffering to those in need

- The Single Convention is clear that while the prevention of diversion is important, it should work together with measures to ensure adequate availability of opioids for medical purposes
- The strict regulation that is characteristic of over-emphasis on diversion control often leads to rules for manufacturing or importing controlled medications, and transporting them to pharmacies, make routine end user access difficult or impossible

Trainer Notes: The overarching thrust of the Single Convention on Narcotic Drugs instructs countries to ensure access for medical purposes, while at the same time ensuring diversion control of licit opioids. Most jurisdictions have tended to over-emphasise control at the expense of access, thus impeding the Convention's mandate and causing unnecessary pain and suffering to those in need. The Convention is clear that while the prevention of diversion is important, it should work together with measures to ensure adequate availability of opioids for medical purposes.

The Convention's diversion control specifications are set out so that member countries have the flexibility to implement them in ways which accord with the Convention mandate, as well as with domestic needs and resources.

The strict regulation that is characteristic of over-emphasis on diversion control often leads to regimes in which the rules for manufacturing or importing controlled medications, and transporting them to pharmacies, make routine end user access difficult or impossible. When excessively burdensome regulations are applied, they can cause blockages in the supply chain.

Activity: (20 minutes)

(For this activity, prepare a small package that will be passed from one participant to another.)

Ask the group to stand up.

Select a participant and give them the butcher paper that details the relationship between the Competent Authority and law enforcement in their country.

Select another participant and give them the paper that details how Convention requirements are applied to growing or manufacture opiods

Select another participant and give them the paper that details how convention requirements for storage are applied

Select another participant and give them the paper that details hopw convention requirements for dispensing and administration of opioid medicines and MAT are applied

Select a participant to whom the package must be given (ie the end-user)

Ask the remaining participants, in turn, to identify places in the chain which restrict the package passing through the chain. Then ask them to identify how and where these restrictions could be lessened without unduly reducing potential for significant diversion.

CASE STUDIES:

Slide 18

A. Control to ensure availability: Experience from Romania

- Romania has made great strides forward in narcotics law reform and the implementation of a new regulatory system capable of providing greater capacity at the prescription end of the medical opioid chain
- While acknowledging progress, some regulatory storage impediments remain
- Licenses are required to store opioids in Romania – whereas the Single Convention specifies only that storage must be managed under legal authority, with lock and key security

Activity: (5-10 minutes)

Direct participants to the case study handout, case study A (provided at the end of this Session). 1 minute reading time.

Summarise case study by referring to slide 13. Invite participants to discuss how might these regulations have come about? Are you reminded of similarities from your own experience in your own country of storage regulations?

Slide 19

B. Control to ensure availability: Experience from the United Kingdom

- The UK government does not provide specific regulations for licit opioid transportation, but does provide guidelines and administer individualised inspections on an ad hoc basis

- The guidelines were created in consultation with the pharmaceutical and shipping industries, and are designed to support transporters to formulate their own control plans by addressing record keeping, checks and reporting
- The UK approach demonstrates how government flexibility in implementing regulatory systems can expedite the supply process
- The UK government has acknowledged that some level of diversion is inevitable, but that such is not cause for extreme concern and disproportionate measures
- The guidelines are generally framed as recommendations, rather than strict and cumbersome requirements

Activity: (5-10 minutes)

Direct participants to the case study handout, case study B (provided at the end of this Session). 2 minutes reading time.

Summarise case study by referring to slide 19.

Invite participants to discuss how these regulations might have come about? Are you reminded of similarities from your own experience in transport in your country?

Slide 20

C. Regulatory reform – the China experience.

Law enforcement agencies played pivotal role in the process of policy reform to reduce legal barriers to pain relief

- The Ministry of Public Security authorised a process of assessment, policy reform and implementation that reduced the legal barriers to pain relief
- Information and applied workshops to address traditional negative attitudes towards opioid medications among government officials and delegates of legislature
- Input from the Chinese Ministry of Public Security helped to establish balance between law enforcement concerns and access to opioid medicines
- Demonstrates drug regulators and law enforcement agencies facilitating improved access to medical opioids

Activity: (5-10 minutes)

Direct participants to the case study handout, case study C (provided at the end of this Session). 2 minutes reading time.

Summarise case study by referring to slide 20

Ask group to ideintify some of the key factors in the success of this regulatory reform. Can any of these be utilised in your country?

Slide 21 - Control to ensure availability: Summary

- Drug control laws and regulations must acknowledge the essential nature of opioid medications so as to ensure access for end users
- Drug control efforts can then become more targeted, focusing on key diversion sources, and thereby facilitating a functional supply chain
- Governments have much flexibility in how to manage the medical opioid and MAT supply chain to satisfy UN Drug Convention requirements
- While potential diversion should be identified and averted, the potential illicit activities of a few cannot be allowed to interrupt or delay sorely needed medical provisions for many.
- Drug regulators should avoid pejorative terms for opioid analgesics in the regulations controlling their prescription and dispensation.

Trainer Notes: Drug regulations should be analysed to ensure the identification and removal of potential bottleneck points and onerous licensing requirements. Healthcare providers should participate in reviews of drug control regulations to assess whether they unnecessarily impede accessibility of pain medications. If regulations are found to impede access, they should be amended. Regulators should ensure an effective supply chain for opioid medicines with regulations or guidelines that address key areas of potential diversion but do not unduly complicate the supply chain. In this way, drug control laws and regulations must acknowledge the essential nature of opioid medications for the relief of pain and suffering so as to ensure access for end users. Law enforcement efforts can then become more targeted, focusing largely on key diversion sources, and thereby facilitating a fluid and functional supply chain.

Governments have much flexibility in how to manage the medical opioid and MAT supply chain to satisfy UN Drug Convention requirements. Cultivation and manufacture require application, central oversight and licensing, while storage and transport must be under 'legal authority' of some description. The UK experience relating to production, storage and transport provides an interesting example of streamlining access to medical opioids by simplifying regulations.

Balanced, proportionate diversion methods must take into account that medical opioids and MAT are essential medications, and that while potential diversion should be identified and averted, the potential illicit activities of a few cannot be allowed to interrupt or delay sorely needed medical provisions for many.

Activity: (35 minutes)

Small groups to develop action plans, followed by presentation to whole group and discussion.

Utilsing the information from this session, and recalling the China reform process, work in small groups to develop a hypothetical action plan for streamlining the medical opioid supply chain (without unduly compromising drug control) in your country. Each group is to feedback to the main group their findings.

At the end of this activity, invite participants to identify key areas they will review once they return to their duties

Case Study A (*with slide 18*)

Storage license requirements in Romania.

While acknowledging progress, some regulatory storage impediments remain. The Single Convention specifies only that storage must be managed under legal authority, and many countries do not impose licensing or further requirement beyond lock and key security. However, in Romania, licenses are required to store opioids. To apply for a storage license, the applicant must provide:

- a completed application;
- a registration number;
- a warehouse license;
- a curriculum vitae of the pharmacists who may interact with the substances;
- the criminal record of the pharmacists involved with the substances; and
- a statement of diversion prevention measures to be undertaken.

Case Study B *(with slide 19)*

Regulating transport of medical opioids; the UK experience.

The United Kingdom (UK) provides an interesting variation of regulation of the transport of medical opioids. The UK government does not provide specific regulations for licit opioid transportation, but does provide guidelines and administer individualised inspections on an ad hoc basis. The guidelines were created in consultation with the pharmaceutical and shipping industries, and are designed to support transporters to formulate their own control plans by addressing record keeping, checks and reporting.

The UK approach demonstrates how government flexibility in implementing regulatory systems can expedite the supply process. The UK government has acknowledged that some level of diversion is inevitable, but that such is not cause for extreme concern and disproportionate measures. The guidelines are generally framed as recommendations, rather than strict and cumbersome requirements. For example, it is advised that whenever diversion of medical opioids in transit occurs, the consignor and the consignee should immediately review their procedures to prevent recurrence. Mishandling has been a problem at transit points, so it is suggested that shipping agents use the most direct route in order to minimise the opportunities for mis-routing or diversion. In the past, when a consignment has gone missing, it has been the practice of some organisations to assume that it has been misdirected and to wait before

reporting. Currently, however, if the consignment is not received at the expected time, it is advised that the supplier should be advised without delay, and the supplier should then promptly report the matter to the carrier, the police and the Home Office. The UK medical opioid transportation system relies mainly on self-regulation by the transport industry and appears to provide a practical and functional framework for facilitating the safe and efficient transport of medical opioids.

Case Study C *(with slide 20)*

Regulatory reform – the China experience.

Law enforcement agencies - working with public health authorities and with support from international community resources – have played a pivotal role in the process of policy reform to reduce legal barriers to pain relief in China. The Ministry of Public Security authorised a process of assessment, policy reform and implementation that reduced the legal barriers to pain relief.

Information was provided and workshops were held to address traditional negative attitudes towards opioid medications among government officials and delegates of legislature. Concepts such as drug tolerance and drug dependence were clarified, and exaggerated fears relating to opioid dependence have decreased. Reform changes encouraging improved opioid medication supply included:

- the Chinese Food and Drug Administration (FDA) became the central agency for production and distribution safety;
- simplified procedures for the production, pharmaceutical management and selling of medical opioids;
- relaxation of restrictions on production, storage, and shipment; and
- restructuring of prescription licensing procedures.

Substantial increases in consumption of medical morphine demonstrate the positive impact of the reform process in China. Training on the use of opioid medications in cancer care is now provided through institutional infrastructure as a requirement for prescribing physicians, and a recent survey has shown improvement in basic knowledge for those physicians who have receive training in cancer pain management. However, fear of opioid dependency continues to dissuade physicians from prescribing morphine, and some barriers in China are yet to be addressed, such as time limits on opioid prescriptions, improving opioid medication access for rural patients, and dispelling stereotypes about palliative care in cancer treatment.

Input from the Chinese Ministry of Public Security helped to establish balance between law enforcement concerns and more streamlined access to opioid medicines for those in need. This example demonstrates a role for drug regulators and law enforcement agencies in not hindering, but instead facilitating, improved access to medical opioids.

Session 7- Assisting Treatment Access for People in, and Released from, Custodial Settings

(Additional Session for corrections officers and prison policy-makers).

Aims: That participants are aware that the same standard and range of medical care available to the community should be available to detainees and prison inmates
Time: 120 mins
Resources: Slides, white board, butchers paper, marker pens
Handouts:

- Country Case Studies
- Examples of policy and procedure for MAT in prisons from Australia

Slide 1 - The need for treatment continuity

- The same standard and range of medical care available to the community should be available to detainees and prison inmates
- Law enforcement, corrections and health need to work together to establish of MAT and pain relief and palliative care programmes within prisons
- To interrupt treatment for pain relief or drug dependency is both unethical and inhumane.
- Where any barriers to continued access to prescribed medications are identified, they should be relaxed or removed.

Trainer Notes: In principle, the same standard and range of medical care available to the community should be available to detainees and prison inmates, whether in custody for a matter of days or years. Where any barriers to continued access to legitimate prescribed medications – including medical opioids and MAT – are identified, they should be relaxed or removed. For prisons in many jurisdictions it is strongly recommended that MAT programmes be introduced for drug dependent individuals. The case for integrating MAT programmes within short and longer term detention and penitentiary facilities is compelling. Drug regulators, police and corrections officers can play important roles in ensuring continuity of access to prescription and MAT medications between community and prisons.

Slide 2 - The benefits of MAT treatment continuity

- reduced non-medical drug use,

- reduced transmission of blood borne viruses,
- reduced mortality
- reduced criminal activity after release
- overdose less likely
- upon release, more likely to enter into and remain enrolled in drug treatment programmes
- reduced challenges in prisoner safety and management

Trainer Notes: It is increasingly acknowledged that the treatment of people receiving pain relief or MAT should be continued if such individuals are moved from the community to prison (i.e. incarcerated), and from prison to the community (i.e. upon release). MAT in prison has been shown to result in reduced non-medical drug use, reduced transmission of blood borne viruses, reduced mortality and reduced criminal activity after release. Prisoners receiving MAT are, upon release, more likely to enter into and remain enrolled in drug treatment programmes, and less likely to experience drug overdose. This requires both linkage between relevant sectors, such as law enforcement, corrections and health, and the establishment of MAT and pain relief and palliative care programmes within prisons, comparable to such programmes in the community.

Continuity of access to all medical opioids is clearly supported when moving into, or out of, custody. For example, Australian national guidelines state that; "Every prisoner is to have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community." The WHO also recommends that patients of MAT taken into custody should be able to continue such treatment. Jurisdictions in which MAT is available in the community are advised to urgently implement such programmes in custodial settings.

Continuity in treatment for pain relief should never be impeded – the alternative is both unethical and inhumane. Continuity of treatment for people on MAT is similarly critical. Without prompt attention, a person on MAT can experience withdrawal symptoms, presenting additional challenges for custodial officers. Studies have shown that people who discontinue MAT upon imprisonment tend to continue to use drugs chaotically both during and after prison terms. Drug overdose post-release from prison is common, partly because of reduced tolerance to pre-imprisonment drug doses. This highlights the necessity for linkages between prisons and community providers. Overdose risk is dramatically reduced where the drug dependent prisoner receiving MAT in prison is provided with an uninterrupted transition to community prescription, post-release. Continuity with MAT access in prisons is also an indicator of retention, with high proportions of those receiving MAT in prisons going on to continue with MAT in the community post-release. To cease MAT upon arrest, and thereafter in prison,

undermines the merits of MAT prescribing along with the benefits to individuals and to the community.

Activity: (10-15 minutes)
Break participants into smaller groups. Ask them to discuss the following and then write on kitchen paper:

- What are the common concerns regarding MAT in prisons'?
- What do you think is the cause?

Slide 3 - Common concerns among law enforcement and corrections personnel related to MAT in prisons.

- 'Prisoners should abstain from drug use while in custody'
- 'MAT just substitutes one drug for another'
- 'Drug users are just weak willed'
- 'MAT doesn't improve anything for me'
- 'MAT doesn't improve anything for inmates'

Trainer Notes: Some police and custodial officers share common concerns and misunderstandings about drug dependency and MAT. If these are different to those devised by the group, make a comment as to how their concerns are different.

Slide 4

'Prisoners should abstain from drug use while in custody'

- Although well intentioned, this notion has proved unachievable in prison systems.
- Drug use and sexual activity continue in prisons, with documented cases of HIV transmission
- Inmates are generally able to access drugs which they can inject,
- MAT has been shown to reduce illicit drug use activity both within and outside prisons systems.

Trainer Notes: One study reported that 50% of inmates were drug injectors, that almost half injected while in prison and that 94% shared injecting equipment. These circumstances, known to lead to HIV outbreaks within prisons, are still common in many jurisdictions, and particularly pronounced in developing and transitional countries. Detainees return home with the attendant risk of transmission to partners, families and communities.

Slide 5

'MAT just substitutes one drug for another'

- The pharmacological properties of heroin are very different to that of medication assisted treatment.
- MAT uses ***long-acting*** opioids such as methadone and buprenorphine which –can stabilise people who are dependent on ***short-acting*** opioids like heroin.
- With a dose per day, MAT prevents withdrawal in drug dependent individuals so that they can function normally in prison or in the community.
- Research has shown that MAT can have a significant beneficial effect upon future drug use, criminal behavior and social functioning.
- The many health and other benefits associated with medication-assisted treatment, including reduced criminal activity and reduced illicit drug use, makes MAT a multipurpose tool in prisoner care and management

Trainer Notes: (If necessary, also revisit Session 3 information on MAT).

Slide 6

'Drug users are just weak willed'

- The WHO and the United Nations Office on Drugs and Crime (UNODC) recognise that drug dependence is a serious health condition. "
- Drug dependence is considered a multi-factorial health disorder that often follows the course of a relapsing and remitting chronic disease.
- Some drug dependency experts liken heroin dependency to diabetes – to withhold insulin from the diabetic is akin to withholding MAT from a dependent person
- MAT has proven the most effective response to illicit heroin injecting in terms of both public health and law enforcement imperatives

Trainer Notes: (If necessary, also revisit Session 2 information on heroin dependence).

Slide 7

'MAT doesn't improve anything for me'

Police and custodial officers report significant benefits associated with MAT provision in custodial settings, including:

- MAT has a positive effect on institutional behaviour by reducing drug-seeking behaviour and improving prison safety;

- a range of common initial concerns among prison personnel (such as increased violence or drug diversion) have not been realised when MAT is actually implemented in prisons;
- prisoners and prison personnel report that MAT has a beneficial impact on the prison culture.

Trainer Notes: Detainee and prisoner case management can be safer and more straightforward when not dealing with individuals undergoing withdrawal or engaging in risky drug taking in prison settings.

Slide 8

'MAT doesn't improve anything for inmates'

The provision of MAT in prison settings has been associated with the following benefits for prisoners:

- reduced injection of illicit drugs;
- reduced HIV and hepatitis infection;
- reduced mortality;
- lower rates of post-release drug use among MAT clients;
- reduction in the use of non-sterile injecting equipment;
- increase in the use of condoms in sexual relationships;
- reduction in the number of overdoses;
- MAT can improve the delivery of ART to HIV-positive drug dependent prisoners.

Slide 9

- Of benefit to MAT clients, law enforcement and the community at large – MAT has a positive effect upon criminal recidivism and re-incarceration
- Re-incarceration is less likely among those prisoners who receive adequate MAT while incarcerated.
- Prison systems in jurisdictions where MAT programmes are available in the community are urged to introduce and scale up MAT for detainees and prisoners.

Trainer Notes: We'll now examine the experience of MAT in prisons across a range of countries.

Slides 10 - Case studies from Iran, India, Poland, USA, and Australia

- Good practice examples of MAT and other medication continuity when moving into custody, or upon release, are available across a range of socioeconomic environments including in resource-poor countries.

Activity: (30 minutes)
Break group into groups of 5 -6 people. Distribute the handout "Country Case Studies" and ask each group to consider what elements of the case studies that might work in their country and why. Likewise, ask each group to identify elements that would not work and explain why.

Each group is then to present back to the group their findings. Conduct a discussion with the whole group to identify the key elements underlying the success or failure of particular strategies.

Slide 11 - Policy and procedures:

To implement MAT in prisons, clinical and operational policy and procedures are required.

They can be adapted from such documents in other countries, and include instructions related to:

- induction
- maintenance programmes,
- clinical monitoring and review,
- service delivery arrangements,
- release referral
- monitoring processes

Trainer Notes: The Victorian Prison Opioid Substitution Therapy Program: Clinical and Operational Policy and Procedures document details instructions for the development of MAT in prisons, along with the aims, objectives and underlying principles for providing MAT in Victorian prisons. The document details practical, programmatic components including maintenance and induction programmes, clinical monitoring and review, service delivery arrangements, release referral and the monitoring and evaluation processes.

Activity: (20 minutes)

Ask participants to work in small groups to identify what sort of practical impediments might be faced in ensuring treatment continuity when moving into and out of custody.

Small groups present a (unified) list of possible impediments. Trainer works through list with participants to develop possible solutions.

Give out Handout 2 – "Examples of policy and procedure for MAT in prisons from Australia" for further reading

Slide 11 - Pain management in prison

- Inadequate pain management is common in prisons
- Systemic and attitudinal barriers

Trainer Notes: Common barriers to pain management identified through interviews with US practitioners and prisoners included concern over drug misuse/diversion, systemic obstacles and lack of prisoner credibility. The power imbalance experienced between prisoners and prison officers is rarely conducive to open and honest communication.

Activity: (20 minutes)
Divide participants into 2 groups. Ask them to work together to identify barriers (structural and attitudinal) to effective pain management in prisons, listed on butchers paper.

For both groups, a spokesperson presents the list to the other group. Whole group brainstorm solutions.

Trainer tips:
Possible solutions could include:

- the use of written contracts between inmates, practitioners and prison authorities.
- the formation of a panel involving pain experts, drug abuse experts, prison authorities, and inmate advocates could examine disputed cases of drug diversion in order to prevent potential discontinuation of pain medication.
- security protocols which restrict pain management could also be reduced through a multidisciplinary approach involving prison authorities and medical personnel.

Slide 12 - Guidance points

The case for integrating MAT programmes into prisons is compelling.

In providing MAT and other prescribing services in prisons, law enforcement and corrections personnel are able to

- minimise harmful drug use practices and
- minimize drug diversion in prison environments
- ensure continuity in treatment if the detainee / inmate is currently prescribed medical opioids or MAT.

In these ways, law enforcement can bring better balance to considerations of public health, public security, human rights, and development.

Trainer Notes: The WHO recommendations regarding MAT in prisons calls upon authorities in countries where MAT is available in the community to urgently introduce MAT programmes within prisons, and to expand implementation to scale as soon as possible. Particular efforts should be undertaken to ensure that prisoners on MAT prior to imprisonment are able to continue this treatment upon imprisonment, without interruption.

The case for integrating MAT programmes within short and longer term detention and penitentiary facilities is compelling. Where any barriers to continued access to legitimate prescribed medications, including medical opioids and MAT are identified, they should be relaxed or removed.

Handouts: Country Case Studies.

In Iran, where MAT has been available through 'triangular clinics' in prisons since 2003, methadone treatment is one component of broader HIV prevention efforts. At the end of 2006 there were 55 'triangular clinics' in prisons in Iran covering 33% of prisoners. Further, there were another 34 such clinics located in after-care centres in the community. By the beginning of 2007, the clinics were providing MAT (in the form of methadone maintenance therapy) for 55% of prisoners in need, with plans to increase coverage to 80-99% by 2008.

In Kolkata, law enforcement is confronted with the problem of people who use drugs going into withdrawal while in custody. As law enforcement personnel are not trained to adequately respond to such situations, working relationships with NGOs are becoming increasingly important. NGO personnel are permitted to enter the prison and deliver harm reduction information and advice. Upon release, prisoners are encouraged to access and utilise drop-in centre facilities and services, including both NSP and MAT programmes. Kolkata law enforcement authorities have expressed their support for harm reduction programmes – including MAT – to be available in prisons in the near future.

Prisons in Poland allow individuals who have been receiving MAT in the community to continue such treatment while incarcerated. MAT is also available in prisons in Australia, Canada and Puerto Rico, but remains of limited accessibility in the USA.

However, even in the USA, trial methadone programmes treated inmates and over time demonstrated statistically significant differences in decreased criminal recidivism among those who received MAT in prison. A prison methadone programme running at Rikers Island from 2000, established the 'model'. A number of correctional facilities have since indicated an interest in using MAT to treat chronic heroin dependence, based on the success of the Rikers Island model. The Rikers Island experience indicates that providing access to such medication assisted treatment in correctional facilities is an extremely effective method of reducing recidivism.

In some jurisdictions, case management models for systemising ongoing access to medical opioids and MAT in prison have emerged. For the many people who enter custody with an alcohol or other drug dependency, incarceration may result in unintended detoxification, which also presents additional challenges for custodial officers. In Victoria, Australia, the Custodial Risk Management Unit provides a collaborative model that could be applied in other jurisdictions. The Unit was established in recognition of the health needs of people in police custody, and to make the transition from the community into custody safe. It works proactively with Victoria Police to improve health outcomes and reduce

risks for people in police care. It is staffed by a doctor and a team of nurses, and supported by a network of general practitioners. Custodial nurses offer a comprehensive health assessment to everyone held in custody, and if necessary a care plan is developed in consultation with a medical officer and the police. The doctors prescribe medication when it is required to continue regular treatment and may initiate treatment for alcohol or drug withdrawal. The nurses help people find pharmacotherapy prescribers, pharmacies and other relevant services. If the person is going to prison, referral is made to the appropriate services in the jail.

The custodial nursing service has been well supported by police. Since the commencement of the current programme in 2002, police report that there has been a dramatic reduction in the number of health and welfare issues in custody. The balance between the health of people in custody and the workings of the justice system can present challenges which the Unit manages through liaison with external agencies to ensure treatment continuation or assessment with potential for MAT initiation. The major success of this unit has been the collaboration between health professionals and the police. By working together in police stations and being involved in the Unit's functions, police have come to recognise some of the complexity of the health needs of the people in their care, and the benefits to custodial management of rapid access to ongoing medical treatment for prisoners. The result has been better care for all people in custody.

Handout 2- Examples of policy and procedure for MAT in prisons from Australia

The Corrective Services Department of the Queensland state government states that:

> "Opioid pharmacotherapy maintenance treatment will be available for remandees and offenders serving sentences of less than 12 months where they were undertaking community opioid replacement therapy at the time of reception to custody. Pregnant female (sentenced) offenders in custody who do not meet the criteria above may undertake opioid replacement treatment for the duration of their pregnancy. Partnership arrangements will be developed with Queensland Health to enable continuation of opioid maintenance pharmacotherapy for offenders following their release."

An individual taken into law enforcement custody should "be afforded the opportunity to receive their regular dose from an authorised prescriber or dispenser," and the custodial officer "should get the name of the detained person's medical practitioner or dosing point and call them as soon as possible," in order to avoid any unnecessary delay in dosing.

Generally, the responsibility for making alternative dosing arrangements for MAT clients taken into custody lies with the prescriber / dispenser. "If a detained person has any take-away doses of methadone on them, these should be taken into possession and accounted for as prisoner property in the usual way. The doses should be recorded as part of the person's property (including whether the bottle/s were full or empty). If the person is in possession of an illegally obtained dose of methadone, police can contact the prescriber (whose name will be on the label on the bottle containing the dose) and tell the medical practitioner what has been found. The name of the person to who the dose was prescribed should also be reported to the prescriber. This allows the prescriber to be made aware that one of his or her clients may have been trading, rather than taking, the daily dose." Other prescription and dosing guidelines provided in the community can be adapted for use in prisons. For example, to minimise diversion, it is advised that dosing take place in view of the dispenser.

Session 8- Conclusion

Aims: Review key areas in providing medical access of opioids by end-users
Time: 60 mins (plus 30 mins for evaluations and certificate presentations)
Resources:

- Attendance Certificates for participants
- Course Evaluation

Law enforcement and improving access to medical opioids and MAT: Conclusion

Slide 1

- Regulatory review as well as policing of medical opioids and MAT supplies must be shaped by the need to ensure sufficient and uninterrupted supply, as well as drug control objectives
- Excessively restrictive drug control regulations or enforcement practices do interrupt or limit the supply of medical opioids and MAT to end users

Trainer Notes: There has been a global tendency towards emphasis on attempts to eliminate illicit drug use and the diversion of medical opioids (albeit with little or no success) by law enforcement, at the unacceptable expense of millions of people who require, but are denied, pain relief and/or MAT.

Where policies are overly restrictive, or hindering access to medical opioids, policy reform is required.

Slide 2

- Governments have substantial flexibility in how to manage the medical opioid and MAT supply chain to satisfy UN Drug Convention requirements
- Any regulations that unnecessarily impede access to medical opioids and MAT are actually inconsistent with both the UN Drug Conventions and the Universal Declaration of Human Rights, which require countries to achieve balance between legitimate availability and preventing illicit activity

Trainer Notes: Fortunately, without altering the stipulations of the UN Drug Conventions, much can be done to rectify the imbalance. Governments have substantial flexibility in how to manage the medical opioid and MAT supply chain

to satisfy UN Drug Convention requirements. Cultivation and manufacture require application, central oversight and licensing, while storage and transport must be under 'legal authority' of some description.

While governments may, under the Convention, impose additional requirements if deemed necessary – such as requiring that all prescriptions be written on government forms – this is an option governments can adopt or ignore according to national needs. As WHO has observed, "... this right must be continually balanced against the responsibility to ensure opioid availability for medical purposes."

Any regulations that unnecessarily impede access to medical opioids and MAT are actually inconsistent with both the UN Drug Conventions and the Universal Declaration of Human Rights, which require countries to achieve balance between legitimate availability and preventing illicit activity.

Slide 3

- To combat misplaced stigma attached to the prescription and use of medical opioids, it is important that regulators and law enforcement understand the need for medical opioids, including MAT, and take a more balanced approach in public messages to physicians and how they handle routine investigations of medical practice

Trainer Notes: To combat misplaced stigma attached to the prescription and use of medical opioids, it is important that regulators and law enforcement understand the need for medical opioids, including MAT, and take a more balanced approach in public messages to physicians and how they handle routine investigations of medical practice.

Slide 4

- Law enforcement must adopt appropriate access to medical opioids and MAT as a core goal alongside control of illicit use
- Working partnerships between law enforcement and the health sector, including MAT providers, will also be required to correct the imbalance.
- In order for law enforcement to operationalise reforms towards appropriate access to medical opioids and MAT, some changes in practice and attitude may be necessary

Trainer Notes: In order for law enforcement to operationalise reforms towards appropriate access to medical opioids and MAT, some changes in practice and attitude may be necessary.

Slide 5

- Diversion prevention methods must be proportionate and take into account that medical opioids and MAT are essential medications
- Responses for medical opioid diversion prevention must be carefully considered and balanced against potential unintended consequences

Trainer Notes: Diversion prevention methods must be proportionate and take into account that medical opioids and MAT are essential medications, and that while potential diversion should be identified and averted, the potential illicit activities of a few cannot be allowed to interrupt or delay sorely needed medical provisions for many.

It should be recalled that, at the international level, diversion of opioid medications from the licit trade into illicit channels remains relatively rare and in small quantities compared to the necessarily large trade flow. Diversion control should be based on evidence to better identify and respond to key diversion sources.

Adjustments may be necessary to better ensure the required flow of licit opioid medications to end users, as well as disrupting any significant diversion sources. Law enforcement must adopt appropriate access to medical opioids and MAT as a core goal alongside control of illicit use.

Slide 6

DCAM website

- Visit the Drug Control and Access to Medicines (DCAM) Consortium website: http://www.dcamconsortium.net/
- The DCAM Consortium website provides a short statement on the issue and the DCAM global and national level solutions, involving a systematic programme of assessment, planning, coordination, and intervention implementation
- The website also presents the DCAM Compendium of INCB Statements on Access to Medicines

- A range of resources with direct links, and searchable by keyword and country, is detailed within the DCAM website
- Those who wish to understand more about improving access to medical opioids are invited to visit the Drug Control and Access to Medicines (DCAM) Consortium website: http://www.dcamconsortium.net/

Trainer Notes: The DCAM Consortium has organized an International Coordinating Committee, bringing together a global group of representatives from palliative care, drug dependency treatment, global health, global drug policy, and other organizations to work together to accelerate policy change. The DCAM website is designed to assist all organizations and individuals interested in accelerating policy change to access the data and guidance materials they need.

The DCAM Consortium website provides a short statement on the issue (with a map of global opioid consumption) and the DCAM global and national level solutions, involving a systematic programme of assessment, planning, coordination, and intervention implementation.

The website presents the DCAM *Compendium of INCB Statements on Access to Medicines*, bringing together INCB statements on a range of specific issues related to the need for medical and scientific access to medical opioids and MAT.

A range of resources with direct links is detailed within the DCAM website. These resources are searchable by keyword and by country.

Slide 7

Key documents

- **Key documents**
- Burris, S. & Davis, C.S. A Blueprint for Reforming Access to Opioid Medications http://ssrn.com/abstract=1356815
- Closing the Gap: Case Studies of Opioid Access Reform in China, India, Romania & Vietnam http://ssrn.com/abstract=1356769
- Review of Global Policy Architecture and Country Level Practice on HIV/AIDS and Drug Treatment http://ssrn.com/abstract=1357336
- WHO Policy Brief on Effectiveness of Drug Dependence Treatment in Preventing HIV Among Injecting Drug Users http://www.who.int/hiv/pub/idu/e4a-drug/en/

Appendix A

EVALUATION FORM FOR PARTICIPANTS

Please rate on a scale of 1 to 4 how useful the following sessions were (circle number)

Session Number	Not Useful	Somewhat useful	Useful	Very Useful
1	1	2	3	4
2	1	2	3	4
3	1	2	3	4
4	1	2	3	4
5	1	2	3	4
6	1	2	3	4
7	1	2	3	4
8	1	2	3	4

2. What was one piece of knowledge, skill or experience you will take away from today and use in your work?

3 What is one thing you would change about today's training sessions?

4 Do you have any other comments?

EVALUATION FORM – TOTAL TRAINING WORKSHOP

Please rate on a scale of 1 to 4 how much you agree with the following statements

1. I feel better informed to address some of the problems of access to medical opioids in my city/region.

1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Disagree

2. I feel more confident in working with individuals who require medical access to opioid

1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Disagree

3. I feel more competent in working with individuals who require medical access to opioid

1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Disagree

4. I feel more capable of discussing access to medical opioids issues with colleagues and people in other organizations.

1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Disagree

5. Which part(s) of the workshop did you like best? Why?

6. Which parts of the workshops did you like least? Why?

7. What information was missing from this training workshop that you think is important?

8. Do you have any other suggestions or remarks?

EVALUATION FORM FOR TRAINERS

1. What did the feedback of participants suggest to you about the relevance of the workshop to them?

2. Briefly indicate, in your opinion, what training benefits (competence, knowledge, social) if any, the participants will have gained from understanding the workshop?

3. With the benefit of hindsight, what additional information would have been beneficial to you for the preparation of this workshop?

4. Please indicate whether, in your opinion, the training methods proposed for this workshop were appropriate.

5. What aspects of the workshop do you believe were most beneficial to the participants?

6. Record the number of participants and gender breakdown.

7. Please comment in general on participant appropriateness. In amongst your own criteria you should consider in regards to the participants for this workshop: their knowledge of the workshop aims; prior understanding of the subject matter; job context; and level of responsibility in their working environment.

8. What changes would you make if you were asked to run the workshop again?

Please comment on any other aspects of your participation in this workshop.