



Law Enforcement Guidance

Prepared for

Drug Control and Access to Medications (DCAM) Consortium

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APMG

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1. Introduction

Millions of people suffer from severe untreated pain caused by cancer, HIV, accidents, surgery, and chronic conditions. Less than 5% of the estimated 13 million heroin dependent people have access to effective, Medication-Assisted Treatment (or MAT¹ – *See section 1.D for a detailed definition of MAT*). In most jurisdictions, the opioid medicines required to effectively manage and treat pain, and MAT for heroin dependence in particular, are unavailable or inaccessible to the majority of those in need. International treaties – namely, the 1961 Single Convention on Narcotic Drugs, as amended by the 1972 Protocol; the 1971 Convention on Psychotropic Substances, and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances – oblige governments to provide access to opioid medicines for pain and heroin dependency. The recent United Nations Commission on Narcotic Drugs 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, and 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.¹

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.

A. *Why this guide?*

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 by those in need.

The World Health Organization (WHO) encourages the following practices for law enforcement in order to better support appropriate access to opioid medicines:

- 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.²

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. 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

¹ Medication-Assisted Treatment, using long-acting drugs such as methadone or buprenorphine, is currently the most effective treatment available for heroin dependence

requires attitudinal changes among law enforcement officials to support reforms in practice. "Law enforcement agencies play an important role in promoting, or inhibiting, healthy behavior."³

Section 1 of this guide explains the context for a more balanced approach regarding the control of medical opioids, and provides definitions of key subject areas and explanations of important background concepts. Rationale, examples and models are described for later adaptation to specific national contexts. United Nations (UN) Convention requirements and practical guidance for the law enforcement role in medical opioid supply – from manufacture to storage – is drawn from the experience of several countries and described in Section 2. Section 3 explains the need for a more considered approach to diversion control and provides some central guidance. Section 4 provides a range of examples of good practice in law enforcement towards improving access to medical opioids and MAT for those in need. Section 5 details ways of improving continuity in medical opioid access for those moving into, and out of, custodial settings. The guide also offers links to relevant supporting documents including those available via the Drug Control and Access to Medicines (DCAM) Consortium website, which centralizes relevant resources.

B. Who is this guide for?

This guide is designed to provide instructive information to all levels of law enforcement, particularly narcotics enforcement at the local, state and national levels, corrective services and custodial officers, and drug regulators.

C. What principles should guide the role of law enforcement in facilitating access to medical opioids?

The International Narcotics Control Board (INCB) recognizes that "the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol establishes a dual drug control obligation for Governments: to ensure adequate availability of narcotic drugs, including opiates, for medical and scientific purposes, while at the same time preventing the illicit production of, trafficking in and use of such drugs."⁴ In addition, the INCB and the WHO have endorsed the principle of balance for use in assessing national drug control policies.⁵

As part of a blueprint for reforming access to opioid medications, the principle of balance is emphasised. 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. This principle also draws attention to the importance of balancing associated law reform with a commitment to effective implementation within an expanded system of medical access which better ensures required flow of opioid medication and MAT to end users.⁶

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;^{7 8 9 10 11 12 13 14}

- flexible, easy-to-access MAT is critical to meeting the needs of heroin dependent people.¹⁵

In relation to Section 5 of this guide on pain management and MAT for prisoners, the current UN system position paper on HIV prevention, care, treatment and support in prison calls on countries to provide “adequate pain management and access to effective, appropriate and compassionate palliative care to a quality standard equivalent to that of the outside community.”¹⁶ WHO also recommends that patients of MAT taken into custody should be able to continue such treatment.¹⁷ The guiding principle is that people moving into, and out of, custody should be provided with continuity of treatment with medical opioids and/or MAT.

D. Opioids for pain relief, heroin dependence and Medication-Assisted Treatment (MAT)

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.

Understanding heroin dependence

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

Drug dependency is a complex condition encompassing a broad range of physical, psychological and social aspects. 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.¹⁸

The majority of people who use illicit opioids (particularly heroin),¹⁹ or who are prescribed opioids for pain relief,^{20 21 22} do not become drug dependent. However, if heroin is used persistently for a significant period of time, some people may develop drug dependency. When people use heroin 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 heroin dependent people report needing to take increasing doses to achieve the same effect (i.e. 'tolerance').

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.^{23 24 25} Tolerance is characterised by a need for markedly increased amounts of the substance to achieve intoxication or the desired effect, and a diminished effect with continued use of the same dose. If a dependent person suddenly stops taking heroin, it takes his or her body a few days to return to normal endorphin production levels. In the meantime, with no heroin 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.

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.

What is Medication-Assisted Treatment (MAT)?

Medication-Assisted Treatment, using long-acting drugs such as methadone or buprenorphine, is currently the most effective treatment available for heroin dependence². 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

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"Drug dependence" is used throughout this paper. In order to understand the difference between "addiction" and "drug dependence," it is necessary to briefly review the history of the evolution of the concept of "drug dependence." During the 1960s, the WHO Expert Committee on Addiction-Producing Drugs made serious attempts to clarify the difference between "addiction" and "habituation," only to abandon this effort and to propose instead the use of the term "drug dependence." In the minds of some experts, this led to the misunderstanding that the meaning of the then new term "dependence" would be the same as "addiction" or "habituation," or both of them combined. This was not the case. As emphasized by that Expert Committee, the term "dependence" carried no connotation of the degree of risk to public health. This was a major difference from the term "addiction," which did carry such a connotation. The same Expert Committee also recommended against efforts to distinguish between "physical dependence" and "psychic dependence," because it felt that all drug effects on the individual are potentially understandable in biological terms. In addition, the Committee noted that "physical dependence" had been confusing to some clinicians because the manifestation of withdrawal syndrome was interpreted as evidence of both "physical dependence" and "drug dependence." From World Health Organization (WHO). *Narcotic and Psychotropic Drugs - Achieving Balance in National Opioids Control Policy: Guidelines for Assessment*. WHO: Geneva. 2000. The term addiction is no longer found in contemporary diagnostic manuals

and shorter-acting opioids such as heroin.²⁶ For the purposes of this document, the American terminology of MAT or Medication-Assisted Treatment has been utilised.

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.²⁷ 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.

There are a number of reasons why people who are dependent on drugs such as heroin may be motivated to seek methadone or buprenorphine treatment, including:

- to reduce, and ultimately eliminate, illicit drug use;
- to re-establish their lives and become more functional members of their community;
- due to an acute crisis in their lives;
- for added stability to assist in undertaking HIV or hepatitis C (HCV) treatment;
- to eliminate financial, physical and social costs involved with heroin use and related lifestyle; and/or
- as a requirement of the criminal justice system in their jurisdiction, by way of early referral into treatment programmes.²⁸

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. Overall, the goal of these treatments is to improve the health, social and economic outcomes for individual drug users, their families and the community. In addition, people receiving MAT report less criminal activity, improved family ties, fewer attempts at suicide, less criminal convictions and assisted adherence to HIV medication. In America, where much research on MAT has been conducted, it has been repeatedly demonstrated that 80% of people retained in MAT programmes will reduce or eliminate their involvement in crime.²⁹

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. Individuals maintained on adequately high doses that completely block withdrawal symptoms, as determined by a medical practitioner, stay in treatment longer and use less heroin than those individuals on lower doses. 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.³⁰

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, and MAT medications are listed by the WHO as 'Essential Medicines'.³¹ 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."³²

Opioids for pain relief

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.³³ Further, 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.³⁴ 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.

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.³⁵ Palliative care for these patients is needed, but is generally in short supply everywhere. In many jurisdictions, the opioid medicines required to effectively manage and treat pain are unavailable, or remain largely inaccessible to those in need. Many of the laws and regulations presenting legal impediments were adopted before substance dependence and the beneficial medical uses of opioids were understood. Weak health care systems, insufficient training, stigmatisation of opioid use, and cost and distribution problems have combined with legal impediments to contribute to the situation of poor medical opioid access.^{36 37 38 39} The impact of these factors upon people who suffer from severe untreated pain is particularly pronounced in developing and transitional countries.^{40 41}

Many national drug policies reflect disproportionate concerns that the use of opioid medications in pain management and palliative care will be diverted to illicit markets and result in patients becoming opioid dependent. 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 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.^{42 43 44 45}

Systems of control and outdated understandings of drug dependency have unfortunately interfered with safe patient access to medical opioids and defeat the purpose of the Conventions. Laws and law enforcement practices have hampered the goal of medical availability. A streamlined approach, based on the international drug conventions, is required in order to adequately address the complexity of medical opioid access.^{46 47} Strategic partnerships which allow the health and welfare sectors to interact with law enforcement are also required.⁴⁸ Experiences from a number of jurisdictions that have recognised the need for improved access to medical opioids, and have succeeded in achieving balance between law enforcement and good medicine, have been synthesised for reference throughout Sections 2 to 5 of this document.

In the following sections, different law enforcement approaches which can improve legitimate access to medical opioids and MAT (following the supply chain from cultivation and manufacture through to end user access) are explored and guidance points provided.

2 Ensuring the safe manufacture, import, transport, and storage of medical opioids

This section summarises UN Drug Convention requirements relating to the manufacture, import, storage, and transport of medical opioids, and then examines the experience of selected countries, highlighting both negative and positive experiences. This section is of particular significance for drug regulators, with implications for the law enforcement role in a more balanced regulation of the medical opioid (i.e. medicines for both pain relief and for MAT) supply chain.

A. *Summary of Drug Convention requirements*

“The Single Convention is the result of the recognition by the United Nations of the fact that the adequate provision of narcotic drugs for medical purposes is indispensable for the welfare of mankind, as well as of the fact that drug addiction is a worldwide social and economic threat. Therefore, the Single Convention aims to restrict the use of narcotic drugs to medical and scientific purposes and to prevent their diversion and abuse, while at the same time ensuring their availability for legitimate purposes. 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.”⁴⁹

The Convention system is intended to ensure medical opioid availability and prevent diversion. 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 jurisdictions, the Competent Authority is supervised by agencies that are part of law enforcement.

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.^{50 51}

In practice, the import regulation requirements set forth in the Single Convention have been effective in preventing diversion from international trade.⁵² 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.

According to the Single Convention on Narcotic Drugs, drug manufacture and production are defined as follows: 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.⁵³

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*).⁵⁴

Manufacture: 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.⁵⁵

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."⁵⁶

Provisions of the Single Convention regulating dispensing and administration of opioids involve relatively straightforward licensing and medical prescription safeguards (discussed in Section 3 below).

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.

B. Control to ensure availability: experience from selected countries

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. Here we explore the experience of three countries – Romania, Australia and the United Kingdom – drawing out lessons on flexibility to increase the availability of opioids for legitimate purposes without overly compromising diversion control. These lessons can be extrapolated to different country contexts.

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.

Example 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.^{57 58 59}

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.⁶⁰

Example from Australia

The Tasmanian poppy industry has been active for more than 30 years and supplies about half of the world's medicinal opioid market. As well as cultivation, initial processing is undertaken in Tasmania and the neighbouring state of Victoria.⁶¹

The Australian federal government and the Tasmanian state government share responsibility for control of the poppy industry, which is undertaken effectively via cooperation between regulatory and law enforcement authorities. The Single Convention on Narcotic Drugs requires control and supervision of poppy growing and production. Fulfilling this regulatory role, the Poppy Advisory and Control Board advises upon matters relating to the cultivation, production and transport of Tasmanian poppy, liaises with Australian government departments and oversees security matters for Tasmanian poppy crops.⁶²

Security issues are coordinated between the Poppy Advisory and Control Board, licensed growers and manufacturers, and law enforcement. Strict controls are maintained over all aspects of poppy cultivation and processing, with Poppy Advisory and Control Board field officers regularly patrolling crops and liaising with the Tasmanian Police Poppy Task Force,

which operates each poppy season.⁶³ During the poppy growing and harvesting season, crops are regularly monitored by Poppy Advisory and Control Board field officers, with any illegal activity investigated by Tasmania Police Poppy Task Force officers.

Trespassing on poppy fields and the unauthorized possession of poppies and poppy products is illegal, with substantial penalties for offenders. According to Hobart's *The Mercury* newspaper, there were 17 thefts of poppy heads during 2008-09. These figures are seen as relatively low and not a cause for concern.⁶⁴ All persons connected with the industry undergo security checks (scanning for criminal history and, in particular, drug related offences) with assistance from police intelligence. Access to poppy fields is restricted to authorised individuals, such as license holders and their employees, company field officers, and employees contracted during sowing and harvesting times. Storage of poppy products is controlled via secure facilities fitted with cameras.⁶⁵ Transport of poppy products from growers to processing companies is regulated as part of existing licensing arrangements.

The Australian poppy industry provides a model demonstrating a partnership approach as part of the role of law enforcement in ensuring safe manufacture, storage and transport of medical opioids. Security checks for manufacture through to transport are provided via collaboration between state and federal governments, an especially commissioned Control Board, licensed growers and manufacturers, and law enforcement.

Example from the United Kingdom

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.⁶⁶

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.⁶⁷ 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.⁶⁸

Guidance points

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.⁶⁹ 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.

3. Diversion control: not hindering access by prescribers and dispensers, and by end-users, to medical opioids

Responsible control is required to limit the diversion of medical opioids. 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. This subject is explored in greater detail in this section on medical opioid access by prescribers, dispensers and end users.

The Single Convention on Narcotic Drugs lays out three minimum criteria that countries must observe in developing national regulations regarding the handling of opioids:

- 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;
- a medical prescription is required before opioids may be dispensed to a patient.⁷⁰

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.⁷¹ 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.⁷²

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.⁷³ 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.⁷⁴

Many of the 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, and excessive limits on types of opioid dispensing sites.⁷⁵ 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."⁷⁶

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."⁷⁷ This can result in restricted access to essential medications for many people in need. Furthermore, even in countries with an exclusive 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. Diversion control measures are often instigated without an evidence base detailing key diversion sources.⁷⁸ "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."⁷⁹

Once key diversion sources are identified, a more proportionate and efficient response can be implemented. Of note, the INCB has also 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.⁸⁰

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.

A. *Diversion control: the unintended impact*

Fear of liability

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,⁸¹ 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."⁸²

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.⁸³

Prescription monitoring

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.⁸⁴ 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.⁸⁵

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,^{86 87} 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.⁸⁸ 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.⁸⁹

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,^{90, 91, 92} and that similar research should guide diversion control efforts in other regions.

Other unintended consequences 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.⁹³ 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 gastrointestinal 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.^{94, 95}

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.

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 including Malaysia, Kazakhstan, China, and Thailand.⁹⁶ 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.⁹⁷

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.⁹⁸ This experience 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.

MAT regulations

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.⁹⁹ 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.^{100 101} Only those with residence permits issued by police are eligible – and these are routinely denied to migrants or others.¹⁰²

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.¹⁰³

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

B. Important considerations towards developing diversion control regulations, policies and practices

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.¹⁰⁴

Article 38 of the Single Convention, 'Measures against the Abuse of Drugs', provides some direction with regard to addressing illicit drug use and treatment of dependency. 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.¹⁰⁵

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.

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.¹⁰⁶

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.^{107 108}

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.

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.

Guidance points

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.¹⁰⁹

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.¹¹⁰

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. Once key diversion sources are identified, a more proportionate and efficient response can be implemented. Measures which do not restrict, delay or interrupt legitimate access to opioid medications can then be implemented and evaluated.

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.¹¹¹

The requirement for special prescription forms is not necessarily excessive, provided that forms are made readily available to prescribers.

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.¹¹²

Drug regulators should avoid pejorative terms for opioid analgesics in the regulations controlling their prescription and dispensation.

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.¹¹³

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.

- 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.

4. Law enforcement assisting access by end-users to medical opioids

In this section some examples of law enforcement working to enable improved medical opioid access are provided, in both the areas of pain relief and MAT. In the pain relief context, drug regulators frequently play a vital role in removing unnecessary obstacles to patient access to medical opioids. The role of law enforcement in the Chinese regulatory reform experience is examined. In the context of improving access to MAT, examples are provided of law enforcement forging linkages with community drug treatment providers, and diverting people who use drugs to drug treatment.

It should be noted that diversion, in this section, refers to the range of models involving the process of diverting a drug-related non-violent offender from the criminal justice system to non-custodial education and/or treatment.

A. Working partnerships between law enforcement and health agencies (including hospitals / clinics providing pain relief and MAT providers)

Some jurisdictions have experienced successful medical opioid access reform with the law enforcement sector playing a central role.¹¹⁴

Medical opioids for pain relief – an example from China

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 applied 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.¹¹⁵

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.¹¹⁶ However, fear of opioid dependency continues to dissuade physicians from prescribing morphine,¹¹⁷ 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.^{118 119 120}

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.

Partnerships between law enforcement and drug treatment (including MAT) providers

In addition to not hindering access (*as discussed in Section 3*) 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."¹²¹

Law enforcement can enhance the effectiveness of MAT by indirectly or directly facilitating access.¹²² MAT is supported as an essential public health service by law enforcement through working partnerships with MAT (and other drug treatment) programmes in some jurisdictions. 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.¹²³

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.¹²⁴ 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.¹²⁵

Law enforcement and health workers should collaborate in order to ensure the effective delivery of MAT 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. 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;
- 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 MAT programme;
- the location of MAT clinics and dosing sites;
- the hours of operation of MAT services;
- the identification of main contact persons within law enforcement and the MAT programmes.^{126 127 128}

Police concerns about MAT

Police have sometimes raised concerns in relation to MAT programmes. The following examples are adapted from New South Wales (NSW) Police Guidelines:

- ***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. Where possible, police should consider liaising with the management of the MAT programme beforehand.¹²⁹

- ***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 (*as outlined in Section 1D of this guidance tool*).

B. Pre-arrest referral of people who use drugs illicitly to health and welfare groups

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.¹³⁰

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.¹³¹ 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.¹³²

Diverting people who use drugs from the criminal justice system

Diversion programmes are generally conducted by police and/or require police input. Diversion strategies examined in this section 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.¹³³

Why divert offenders?

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.

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.

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.^{134 135}

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.¹³⁶

C. Post arrest referral of non-violent drug offenders to drug treatment

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. 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.¹³⁷

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.¹³⁸

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.

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. The results are very encouraging. Graduates of drug courts are, according to current evaluations, 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.¹³⁹

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.¹⁴⁰ 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.¹⁴¹

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.¹⁴²

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.¹⁴³

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. The authors found that "... to deny drug court participants the option of receiving medications for their treatment is in our opinion unethical."¹⁴⁴

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.^{145 146}

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.¹⁴⁷

Guidance points

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.¹⁴⁸

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 section 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.

5. Assisting ongoing treatment for people in, and released from, custodial settings

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 an important role in ensuring continuity of access to prescription and MAT medications between community and prisons.

A *The need for treatment continuity*

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.¹⁴⁹ 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.¹⁵⁰ 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.^{151 152}

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.”¹⁵³ The WHO also recommends that patients of MAT taken into custody should be able to continue such treatment.¹⁵⁴ Jurisdictions in which MAT is available in the community are advised to urgently implement such programmes in custodial settings.¹⁵⁵

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.¹⁵⁶

B Common concerns among law enforcement and corrections personnel related to MAT in prisons.

Some police and custodial officers share common concerns and misunderstandings about drug dependency and MAT. Below is a list of conflicting perceptions related to MAT in prisons, followed by evidence-based responses.

'Prisoners should abstain from drug use while in custody'

While this may be a well intentioned notion, it has proved unachievable in prison systems. Drug use and sexual activity continue in prisons, and there are documented cases of HIV infection within such settings.¹⁵⁷ While inmates are generally able to access drugs which they can inject, restrictive policy means that sterile injecting equipment is less available, and that sharing of non-sterile injecting equipment is the norm. One study reported that 50% of inmates were drug injectors, that almost half injected while in prison and that 94% shared injecting equipment.¹⁵⁸ These circumstances, known to lead to HIV outbreaks within prisons,¹⁵⁹ 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.¹⁶⁰ MAT has been shown to reduce illicit drug use activity both within and outside prisons systems.

'MAT just substitutes one drug for another'

In fact, 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 – if provided for a sufficient (sometimes lengthy) period and at a sufficient dose – can stabilise people who are dependent upon heroin and other short-acting opioids. 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 treatment for drug dependent offenders during and after incarceration can have a significant beneficial effect upon future drug use, criminal behavior and social functioning. "Combining prison and community-based treatment for drug addicted offenders reduces the risk of both recidivism to drug-related criminal behavior and relapse to drug use."¹⁶¹ 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 (*see also Section 1D on MAT*).

'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."¹⁶² Withdrawal or detoxification in dependent drug users is ordinarily followed by repeated relapse. 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 (*see also Section 1D on heroin dependence*).

'MAT doesn't improve anything for me'

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. Police and custodial officers report significant benefits associated with MAT provision in custodial settings. The common experience is that:

- 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.^{163 164}

'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.

Furthermore – and of benefit to MAT clients, law enforcement and the community at large – MAT has a positive effect upon criminal recidivism and re-incarceration, particularly if methadone is provided for longer, uninterrupted periods and if moderate-to-high doses of methadone are provided. It has also been found that re-incarceration is less likely among those prisoners who receive adequate MAT while incarcerated.^{165 166 167}

Therefore, prison systems in jurisdictions where MAT programmes are available in the community are urged to introduce and scale up MAT for detainees and prisoners.

C Examples of good practice 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.¹⁶⁸

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 2008.¹⁶⁹

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.¹⁷⁰

Prisons in Poland allow individuals who have been receiving MAT in the community to continue such treatment while incarcerated.¹⁷¹ MAT is also available in prisons in Australia, Canada and Puerto Rico, but remains of limited accessibility in the USA.¹⁷²

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.¹⁷³

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.¹⁷⁴

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.¹⁷⁵

Also by the Victorian Police in Australia, 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.¹⁷⁶

The corresponding policy document of 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.”¹⁷⁷

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.¹⁷⁸

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 whom 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.”¹⁷⁹ 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.

Research from the US indicates that under-treated pain is common among prisoners. Further, analysis has shown that survival for cancer patients in prison was substantially inferior to that of a non-incarcerated.¹⁸⁰ Common barriers identified through interviews with 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. The authors suggest that one solution to evident trust issues could be the use of written contracts between inmates, practitioners and prison authorities. In addition, 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. Prison security protocols which restrict pain management could also be reduced through a multidisciplinary approach involving

prison authorities and medical personnel. Educational sessions on pain assessment and management can address the lack of capacity for primary care practitioners.¹⁸¹

Guidance points

The case for integrating MAT programmes within short and longer term detention and penitentiary facilities 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 drug diversion in prison environments, and 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.

Where any barriers to continued access to legitimate prescribed medications, including medical opioids and MAT are identified, they should be relaxed or removed. 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."¹⁸²

6. Conclusion

The experience and guidance presented above is not exhaustive, but provides the context for law enforcement measures towards improved legitimate access to medical opioids and MAT.

In order to successfully establish training and guidance for law enforcement regarding access to essential medical opioids, policy must match practice at all levels. Where policies are overly restrictive, or hindering access to medical opioids, policy reform is required. 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. 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. Excessively restrictive drug control regulations or enforcement practices do interrupt or limit the supply of medical opioids and MAT to end users.

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."¹⁸³ 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. The UK opioid transport experience provides an interesting example of streamlining access to medical opioids by simplifying regulations.

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.¹⁸⁴

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. For example, 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.¹⁸⁵ Diversion control should be based on evidence to better identify and respond to key diversion sources. Responses for medical opioid diversion prevention must be carefully considered and balanced against potential unintended consequences. 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. Working partnerships between law enforcement and the health sector, including MAT providers, will also be required to correct the imbalance.

7. 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/>

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 problem (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.

8. Annexes

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/>

WHO Evidence for action technical paper: Interventions to address HIV in prisons: Effectiveness of interventions to address HIV in prisons
http://www.who.int/hiv/pub/idu/prisons_effective/en/index.html

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