IDHDP
INTERNATIONAL DOCTORS FOR HEALTHY DRUG POLICIES

SUMMARY REPORT OF PRESENTATIONS AT IDHDP SEMINAR IN BEIRUT APRIL 2011

HOW DOES DRUG POLICY AFFECT A COUNTRY'S DRUG TREATMENT?

Introduction

The aim of International Doctors for Healthy Drug Policies (IDHDP) is to provide an organisation where doctors can build a bridge between evidence based practice and drug policy; to encourage doctors to increase the participation of medical doctors in drug policy reform; to lobby internationally to influence changes in drug policy to promote harm reduction and create healthy drug policies and step up as leaders to influence policy in their countries, and to support doctors who struggle to do this in isolation. We now have 115 members from 38 countries across the world (as represented on the interactive world map): **http://tinyurl.com/IDHDPWorldMap**

This seminar was held at the Harm Reduction International (HRI – formerly the International Harm Reduction Association) conference in Beirut on 5 April 2011 with the purpose of having an overview of members' countries drug treatment system and how this is helped or hindered by the drug policies in their country. Throughout the seminar the presentations reflect the experiences of doctors who have to work in their respective countries within the policy framework of that country to deliver a service to their patients. A broad range of experiences are described, from countries where there is a complete absence of drug treatment and policy; countries where policy is prohibitive to drug treatment; countries where treatment is emerging; to countries who have fair to good policies that have been established for some time. Some of those now under threat – however, many highlight similar issues, for example the impact of stigma, where there is interface with law enforcement, or when a change in government interrupts progress in putting policy into practice.

We know drug policy - probably more so than any other area of health - is particularly vulnerable to political influence that has little to do with evidence-based medicine and it is important to identify this and challenge where it is happening.

Each presenter highlighted the main points where policy has implications for practice in their countries and the opportunities and challenges that exist because of it.

England - Chris Ford, Clinical Director IDHDP and GP

England, like many others have had a range of policies over the past 30+ years. The increase in the heroin problem in the 1980's brought the first psychiatry-dominated specialist services with a dominance of abstinence-based treatments and questioning of the previous harm reduction approach. With the heroin problem continuing to rise, the emergence of HIV an Advisory Council on the Misuse of Drugs report at that time, the return of harm reduction and a marked change in policy emerged. It is hopeful to remember that the Conservative government brought in harm reduction, needle exchanges etc. 1995 onwards brought further policy change which supported drug treatment as being worthwhile and encouraging GPs to get involved. In 1998 *Tackling Drugs to Build a Better Britain* brought new monies and new policy.

Many working in the field have felt sad that much of the money for drug treatment since 2004 *(Tackling Drugs, Changing Lives)* and 2008 *(Tackling Drugs: protecting families and communities)* through to 2010 came via the criminal justice system rather than the health system, but the increase in funding had a positive impact in terms of getting more people into treatment and it drove up quality. Last year there was a dramatic change in government in

England to a coalition administration, who took a drugs policy more or less 'off the shelf' and made a strong call for abstinence, there was talk of a time limited policy for prescribing methadone, and it was said that methadone is not cost effective.

However, there was a lot of resistance to this from various quarters and a good show from various groups who put forward the evidence base, which had the effect of influencing the initial thinking to the point where a more balanced Drug Strategy titled '*Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'* was published in December 2010. The strategy has recovery at its heart, much more responsibility is placed on individuals, with a more holistic approach and new inclusions of the importance of housing, employment, offending, localism, and crackdown on dealers. Whilst it does not say too much about harm reduction, it is important to note that it is also sufficiently broad that it provides the platform to go forward for doctors to do what they need to do, because the policy does not prevent doctors from carrying out their work.

There are many challenges at the moment, not least - for the first time in the UK - the government forcing privatisation into the healthcare system. The concern about this is that because of the economic situation, the social structure is under attack and dramatically reduced. As always, there are opportunities and challenges. All the countries represented in this report will be at different points or stages in the development of drug policy in their countries, but in England, what is needed now is for the existing good system to be defended, developed and supported and to ensure that the gains of the recent past are not lost. It is important for doctors to stand up and challenge policy when it does not serve them in their ability to do their work, and to be leaders in the drugs field.

Summary of current issues:

1. England is at a different point to many other countries
2. Drugs policy has come a long way but doctors need to defend and support the system and develop it further.
3. Doctors need to be allowed to do the job, based on the evidence and not based on the opinions of the current government.

Afghanistan - Amin Zemaray, OST Co-ordinator

Afghanistan is facing serious problems and difficulties related to government policy - and implementation of those policies - in providing for its drug users. It is a fact that Afghanistan is one of the countries responsible for producing more than 90% of the heroin in the world, and the country is facing a growing drug dependency problem. There are approximately 1 million adult drug users representing 8% of the population aged between 15 and 64. There is an increase of epidemic proportions in HIV/AIDS, especially amongst injecting drug users, with figures having risen from 3% in one city in 2006 to 7% in three cities in 2009. The rate for the increase in hepatitis C prevalence is equally alarming – 40.3% in 2009 compared to 36.6% in 2006. The figures for drug users (especially heroin) have increased from about 50,000 in 2005/06 to 120,000 – an increase of 140%.

Until recently there was no policy of harm reduction or opioid substitute prescribing (OST) in Afghanistan. In 2005 the Ministry of Health (MoH) accepted a comprehensive policy of harm reduction. At this time there were about 47 detoxification centres in Afghanistan, supported by donor funding. Due to the high production of heroin in Afghanistan there is also a Ministry of Counter Narcotics (MoCN) and this agency is causing the biggest problem for taking forward the work. The two Ministries involved do not work together towards a co-ordinated drug policy. For example, since February 2010 Dr. Amin has worked in a pilot programme run by *Medecines du Monde* which was established to provide OST for up to 200 patients. The pilot was scheduled to conclude in July 2011, but unfortunately, although Afghanistan produces 90% of the world's heroin, it has to import methadone and buprenorphine from outside of the country and in order to do this, certificates are needed from the Ministry of Counter Narcotics. Just 3 months into the programme, the MoCN called for an evaluation of the project, which effectively halted the pilot at that time. Since then, nothing has happened for eight months. During this time there have been major issues with funding, despite support from the MoH and non-governmental organisations (NGOs). On two occasions there were severe shortages

of methadone causing immense suffering to the 71 patients that had been recruited on to the pilot. On the first occasion, the clinic managed to overcome the issues, but on the second occasion it resulted in the tragic deaths of four patients. Another consequence of this disastrous situation has been the loss of the trust of the patients and some have returned to heroin including injecting. It has also contributed to increased HIV prevalence amongst the patients.

Part of the problem is that the MoH and WHO publicly express their support for OST and the policy of harm reduction, but are unsupportive at implementation level. The US contributes $80million for drug treatment in Afghanistan but with the condition that it can only be used on detoxification centres, and cannot be used for OST. The MoCN is involved in the detoxification centres mentioned earlier and these are funded by UNODC, but these are not detox centres in the proper sense of the word, rather patients undergo 'cold turkey' there and as a result people are in and out of these centres, some as many as 10 times, and become frail and ill. These detoxification centres are hopelessly inadequate for the population, and operate as private businesses and provide a good income for certain individuals, with the support of MoH and MoCN. Drug users are not accepted by hospitals for treatment. There is widespread ignorance around OST.

Afghanistan needs support from IDHDP and from donors to influence or put pressure on or lobby the MoH and MoCN, and also on UNODC and other donors who fund the detoxification centres, not necessarily to close them down, but to ensure that they make available a proper choice of a range of treatment to patients.

Summary of current issues:

1. Challenge US money going into detox centres only
2. Address the uncertain supply of methadone and buprenorphine
3. Get government support for OST

Netherlands - Simon Boerboom

There is a general perception that the Dutch have good drug policy and it may be so that there exists a policy of harm reduction, yet all is not as it seems in the Netherlands.

There is a lack of understanding amongst professionals. For example, Dr. Boerboom received a call from an esteemed colleague who had admitted one of his patients to a psychiatric hospital who told him that the patient was not addicted to heroin at all and that the past 20 years that he had been on methadone was a mistake and had caused him more harm than good, and that therefore he was being taken off the methadone prescription. Two weeks later they discovered just how wrong they were!

Another example is around needle service provision in prison – there are no needle exchange facilities in prisons in the Netherlands – the prisons are drug free zones and patients are detoxed when they enter prison. The philosophy is that they will not relapse – because 'there are no drugs in prison'!

A further example is where different areas have different rules governing the prescription of methadone, such as The Hague where there was a rule for some time that a maximum of 75mls of methadone could be prescribed, so if a patient on 150ml transferred to The Hague, they would be promptly reduced to 75mls.

There are drug using rooms in the Netherlands but the intake process is lengthy; if someone presents at a needle exchange and are not registered there, they will not get needles. The Dutch police take methadone off people when they are arrested, but at least it is returned on release. There are not high sanctions on selling drugs, so dealing is viable and good quality heroin is available. There are no special regulations attached to prescribing methadone – every GP prescribes methadone. So in summary: the regulations are good - but regulations have to be applied by people.

Summary of current issues:

1. Not all as it seems on paper – there are variations in how policy is applied
2. Campaigns are needed for improved prison drug facilities

Egypt - Doaa Oraby MD PhD

Egypt as a country is in the centre of the Middle East and is a leader. Egypt is the bellwether for the region, it is the political and cultural heart of the Arab world, and is always inspiring people in a whole different way. Hopefully the next move will be in the area of implementing harm reduction in all Arab countries.

There is a low HIV prevalence in Egypt, which is in part attributable to the conservative culture, laws prohibiting commercial sex and trade of narcotics. Egypt has a low prevalence of HIV among the general population (0.02%). An estimated figure, from a survey conducted in 2007 by AIDS Project Management Group (APMG) based in the UK, for injecting drug users (IDU) in Egypt ranged from 57,000 to 120,000. The second round of biological behavioural surveillance survey conducted in 2010 revealed a concentrated epidemic among IDUs. Furthermore, Egypt is passing through demographic transition with youth bulge. Youth practice risky behaviours due to immaturity and curiosity in addition to poverty and unemployment. Hence, this is a time where culturally adapted cost effective interventions are urgently needed.

There exists a golden opportunity now for harm reduction in Egypt, because the prevailing religion is that of Islam, and the Islamic religion has two basic tenets that are in strong favour of harm reduction. The first one is *do no harm to others,* and the second one is that *the worst harm is eliminated by a lesser harm*. Another factor is that IDUs are the least stigmatised group and performing an intervention for this group is accepted and provides a safe entry point to other more stigmatised groups such as female sex workers and men who have sex with men.

The local context, however, is that methadone is illegal and cannot be prescribed in Egypt for the treatment of drug dependence – it is viewed as replacing one addiction with another and there are concerns about the potential of it being diverted onto illicit markets. Drug dependent patients in Egypt are mostly likely to be treated for withdrawal symptoms by prescription of sedatives and painkillers.

Regarding needle service providers, there are currently 3 projects operating in Cairo funded by external foundations. There is a needle distribution component in these services, but there is no provision for needle exchange, because in Egypt moving around with contaminated needles is an issue because of the risk of arrest. Therefore uptake and consumption of new needles in these projects is low and exchanging used ones does not occur. Sterile needles are affordable and available from pharmacies. There is a mix of interventions including outreach by former drug users, peer education that includes messages around safe injecting, safe sex and use of condoms. Management of TB and hepatitis B and the distribution of anti-retroviral drugs are via a national AIDS programme.

A main issue for drug users is the high prevalence and large problem of hepatitis C virus (HCV) – it is around 10% - 14% of the general population and much higher amongst IDUs and it is not a current component of harm reduction projects. People who are working in the field need national guidelines and policies and these need to be available in Arabic.

There is planning and work being done towards introducing methadone, but research needs to be done *in Egypt* to prove that it is effective and that it will be accepted locally. Evidence is needed to convince the government of Egypt that OST must be implemented, and that it offers hope, not harm.

Summary of current issues:

1. Grasp the opportunity presented by the Islamic principle.
2. Programmes needed to address HIV and HCV in people who use drugs

3. Work, including research, needs to be done in Egypt to show OST is effective and should be available.

Australia - Craig Rodgers, Medical Unit Manager, Kirketon Road Centre, Sydney

Harm minimisation, incorporating supply reduction, demand reduction and harm reduction strategies has formed the basis of Australia's National Drug Strategy since 1985, and this philosophy is reflected in all drug and alcohol policies at national and state level.

Australia's population is approximately 22 million with an estimated105,000 people who inject drugs (0/4% of the total population). The economic cost to the country of all drug use in 2004-05 was $55.2b of which illicit drugs made up 14.6%. IDU has remained relatively stable from 1993 to 2007. A survey published by the Drug Policy Modelling programme in Australia concerning the public opinion of drug use shows that drugs and drug abuse is not a major issue for many Australians who consider alcohol use to be a bigger problem.

A national needle and syringe program survey is conducted annually across Australia that provides essential information on people who inject drugs and drug use trends. From this, two thirds of respondents are male, 50% or more report daily injecting, heroin is the drug reported to be most commonly last injected, pharmaceutical opioids are the third most primary reported drug injected. HIV seroprevalence has remained quite low at less than 2% and Hepatitis C seroprevalence has decreased from 60% to 50% in 2009.

Regarding government spending on drugs, the majority of the budget is allocated to law enforcement at 55%, with prevention programs at 23%, and drug treatment at 17%. The amount of the government's drug budget spent on harm reduction is comparatively low at about 3%.

Needle and syringe programmes (NSP) have been available since 1987 and are widespread, mostly in fixed sites, although there are also secondary sites such as in hospitals, pharmacies and many NGOs.

Harm reduction strategies employed include NSP and pharmacotherapies, which include methadone, buprenorphine, buprenorphine/naloxone, and the first medically supervised injecting centre in the developed world. Whilst Australia was leading the field in harm reduction for many years there have been no new harm reduction initiatives over the last 10 years.

Statistics for pharmacotherapies are as follows: methadone has been available since 1969, and buprenorphine since the early 2000s. In 2009 there were only 43,000 pharmacotherapy clients with the split between methadone and buprenorphine being 70/30 from 1350 prescribers nationally. The majority of pharmacotherapy clients (64%) receive treatment from private prescribers, often at significant cost to the client. There is often a lack of pharmacotherapy programs in rural and regional areas.

Concerns include a lack of new harm reduction initiatives, lack of government spending on harm reduction and potential saturation of publicly funded drug and alcohol clinics, lack of regional services, the cost of private clinics, limited pharmacotherapy prescribers – and an ageing cohort of prescribers.

Summary of current issues:

1. Harm reduction has been at the centre of drug policy since 1985 but there is a lack of new initiatives.
2. Lack of government funding spent on harm reduction.
3. Lack of drug treatment expansion in last 10 years with potentially unmet treatment needs for PWIDs.

Tanzania - Sharon Stancliff

Zanzibar, an island off the coast of and part of Tanzania on the African mainland, has a population of 1 million. There are approximately 4000 people who inject heroin since it took hold in 2001, and there is a concentrated epidemic of HIV among IDUs. Working in Zanzibar for the past few years, it became clear that the point was more about what could be done to work within the existing framework rather than immediately trying to make policy changes.

Starting in around 2008 there was very little outreach to drug users, methadone was not thought about, and syringe access was available in pharmacies, but had been recently discouraged by the government. Rather like in Egypt, IDUs are among the least stigmatised members of the population, partly because it affects so many families. In 2008 it was decided to look at developing a programme and funding was obtained. Although at this time there was very little outreach to drug users, there were outreach workers who had an informal policy amongst themselves and it grew beyond the outreach workers, and really quickly people learnt through a system of peer education, for example things moved to bleach being available, soon followed by several agencies giving out condoms. A natural progression then would be to start giving out methadone, but the refrain was '*we're not ready'*. A variety of groups then did a lot of education about methadone, which contributed to desensitisation about it.

Something important that Dr Stancliff had noticed was that in the US and then also in Tanzania, overdose prevention was a unifying factor – overdose was identified as a huge problem, both by the Department of SU and by people on the streets. Someone kept an informal list recording these overdose occurrences, which grew till it became important and of value. Soon there was a small campaign about overdose and prevention with naloxone, and policy makers and stake holders became interested. A meeting had been arranged which attracted a great deal of interest from policy makers and stakeholders – so much so it had to be moved to a larger room. Government officials became engaged and rapidly agreed to a very modest naloxone programme. This paved the way for the message "methadone prevents overdose" to be conveyed and by the end of that meeting, it was agreed to adopt the mainland's methadone guidelines.

Having moved naloxone from the operating room to the outpatient clinics, matters have progressed and methadone - already a licensed product in Tanzania - was accepted as a treatment option and licensed and began in Dar es Salaam in February 2011. The government had said 'don't sell needles', but because the policy was not changed, pharmacists and various other groups got together and applied the Islamic principle that the doctor from Egypt spoke about and said 'Well, we need to sell needles', and the establishment of NSP in this way was really brought about by the pharmacists doing their job. The hope is that this now paves the way for more policy change regarding needle service provision and overdose prevention. It has been a very interesting process to experience at first hand - what is now needed is a policy change to put the policy in the hands of the drug users.

Summary of current issues:

1. Support roll-out of OST started in October 2010
2. Support roll-out supply of naloxone
3. Support drug user advocacy

Kenya - on behalf of Dr David Ndetei, Professor of Psychiatry University of Nairobi & Director, Africa Mental Health Foundation (AMHF)

The Kenyan Government has ratified three major United Nations Conventions on Narcotic Drugs and Psychotropic Substances. These are: the Single Convention on Narcotics, 1961; the Convention against Illicit Trafficking on Narcotic Drugs and Psychotropic Substances; 1988, and the Convention on Psychotropic Substances 1971. The latest legislation against drugs in Kenya is *The Narcotic Drugs and Psychotropic Substances (Control) Act, 1994.*

There is no official national drug policy in Kenya for illicit drugs, the only framework to work with in this country is a national policy which governs the distribution of medicinal drugs in hospital.

An anti-drugs approach is taken by the authorities and the National Agency for the Campaign Against Drugs (NACADA) was established and has been tasked, together with other stakeholders with creating a drug and alcohol policy. In a large harbour city, Mombasa, after a recent crackdown on illicit drugs there, it highlighted a great gap in service provision when many people who needed it were unable to get treatment. Treatment in Kenya is for the most part in the hands of prohibitively expensive private rehabilitation centres which are well beyond the reach of ordinary Kenyans. There is a pressing need for the government to urgently develop a comprehensive drug policy which will make treatment available for the general population.

Summary of current issues:

1. Urgent need for development of drug policy to support treatment
2. Lack of affordable treatment options for general population

Indonesia - James Blogg

The drug policy in Indonesia is generally supportive of harm reduction, and the history of harm reduction in Indonesia is that NSP was started in the late 1990s by a number of NGOs, supported by Australia. Methadone has been going since 2004 in 65 sites. Originally buprenorphine was supplied mostly by private providers and this proved to be immensely costly and problematic as people were injecting frequently – some up to 5 or 6 times daily. Recently injectable buprenorphine has been sourced and is being produced in India, and will be able to provide it more cheaply than the cost for example of filters, which was another option under consideration as a harm reduction measure. The advantage of injectable Buprenorphine is that the bio-availability is so much higher and it is hoped in time that the manufacturer will be able to formulate a bigger ampoule.

On the policy side, the 'SEMA law' from the Supreme Court in 2009 reminded the judiciary that they have the right to refer people to treatment, not to jail. This was followed again by a circular in 2010 and a new law that gave the provision for *vonis rehabilitasi* (absolute conviction rehabilitation) as an option as a sentence. There is another new law which was pushed through – 'compulsory reporting' – which requires that drug users and their families must report to either a health or a treatment or law enforcement facility. This law was steamrollered through and caused a great deal of concern. One of the NGOs decided to pilot this system in West Java and surprisingly, got it to work in a positive manner when someone on being arrested reported that he was registered according to the compulsory reporting law, and this was verified and he was subsequently released. So with good will it can work. An almost greater worry is that there is a database being set up between health and the National Narcotics Board which will be cross checked. There is still the matter of working out how to deal with the confidentiality issue.

It is encouraging that there is an increased recognition under the law that drug dependency is a health issue. With reference to the earlier presentation by the doctor from Afghanistan, and the difficulties with the narcotics ministry, the same problem existed in Indonesia, but with really intensive work, a very helpful relationship has been developed and work can be done to expose the officials to a best practice approach and the evidence base. For this to work, it requires trust between the Ministry, the police, NGOs and the people that use drugs.

In considering the issues in Indonesia - on the plus side, the country is very open to new ideas, there is much innovation, and drugs are considered to be a public health emergency. A cause for concern is that the money comes from abroad, when in fact the government has money. It is a matter of getting them to invest internal funding in harm reduction services.

Summary of current issues:

1. Drug policy generally supportive and there is innovation
2. Concern regarding new law on compulsory reporting to police of users and their families
3. Concern regarding overlay of database between health data and National Narcotics Board.

Switzerland - Robert Haemmig, President, Society of Addiction Medicine.

In Switzerland there are 3 Federal expert commissions on substances - a drug, alcohol, and the tobacco prevention commission. Harm reduction is accepted by the drug commission, partly by the alcohol commission, whereas the tobacco prevention commission is still not comfortable with the idea of harm reduction.

However, the Federal Office of Public Health commissioned them to draw up a mission statement for future challenges in substance policy and they delivered a highly interesting report: "*The challenge of addiction: the basics of a sustainable approach for drug policies in Switzerland*". The report is based on the principles of public health and could serve as guidance for any country's policy.
Link to download: http://tinyurl.com/the-challenge-of-addiction

Narcotic law: a revision of the narcotic law was accepted in a popular vote in 2008 which will be active in summer 2011. This revision will bring a proper legal base for harm reduction as part of a 4 pillar drug policy.

Also, it will provide a proper legal base for heroin-assisted treatment and probably some loosening of the strict regulations (e.g. take home doses for stable patients). Cannabis was so far the most forbidden drug in Switzerland and the revision will allow medical marijuana in the future.

Until now, any new substance was scheduled as "forbidden narcotic" (comparable to schedule I), which hinders all scientific work with the substances. This should be changed. The Swiss Society of Addiction Medicine (SSAM) published medical recommendations on "substitution-assisted treatment", based on evidence based medicine. The Federal Office of Public Health, in accordance with the Medical Officers of the Cantons, produced a paper based on the work of the SSAM.
Download both documents http://tinyurl.com/SSoAM-Clinical-Recommendations

More than 50% of patients get their substitution treatment from GPs and pharmacies.
The gap between harm reduction and treatment is bridged in part by OST being available in two safer injecting facilites (SIF). Cannabis consumption has declined, but "coma drinking" is on the rise in young people. There is a debate in parliament to change the actual cannabis regulation in the narcotic law.

Nitelife: for many years now, there is punctual pill testing with a mobile laboratory.

Prisons: in most prisons continuation of OST is possible, in a few also start of an OST; needle exchange programmes are only available in a few.

Summary of current issues:

1. All policy is under public health
2. Changing drug pattern with binge drinking in young people is a serious problem
3. Need more policy about co-morbidity

US - New Mexico - Bruce Trigg

This talk was limited to remarks about OST. There is currently a disturbing trend in that buprenorphine is getting lot of positive publicity – and it is often compared with methadone as being bad, an evil medication. The context of this is that there is a real and dramatic increase in the misuse of prescribed opiates - pain medications - in the US. In many states in the west

there are already more deaths from prescription drug induced overdoses than motor vehicle accidents (MVA) and compared with MVA, homicides, and suicides. The drug induced deaths have been quite dramatically increasing. In both urban and rural communities there are many more opioid analgesic overdose deaths than heroin deaths, even more so in rural areas that have traditionally had less of a heroin problem. But even in cities, there are now 2 to 3 times more deaths - in fact, there are more deaths from prescribed opiates than from heroin and cocaine combined now. Another factor that is emerging is that almost as many young people start using pain relievers as marijuana as their first illicit drug use and if tranquillisers are added to that list – it's a trend.

In New Mexico there are two medications prescribed for opioid addiction - methadone and buprenorphine. There are about a million estimated heroin addicted people in the US and several million addicted to opiate pills. Methadone has been around since the early 1960s. A small, but steady number have been on methadone, but the number of patients on buprenorphine has dramatically increased since 2005. Medications are handled differently in the US than in other parts of the world, methadone can only be prescribed for opiate addiction through narcotic treatment programmes, which are free standing treatment programmes that have to follow a number of federal and state regulations that requires directly observed therapy for generally 90 days to get 1 take home dose; and then it gradually increases so after 1 year of treatment the take home dose is for about 2 weeks. It also requires regular urine testing and counselling, which is both a strength and a drawback.

Buprenorphine is prescribed by any physician who takes a required 8 hour training to be licensed. The problem is that there are not nearly enough primary care physicians who are interested in providing this, so the U.S. has only had buprenorphine available since 2002 – properly only really since 2004 – a relatively short period in the US. Physicians, who are licensed, can have 30 patients simultaneously receiving prescriptions in the first year and after 1 year up to 100. This means that there is a limit on the number of patients that can be treated by any single clinician. Buprenorphine in the US is combined with naloxone in a formulation called Suboxone, taken sublingually, more recently it has become available in film format. The advantage is that naloxone is inactive if taken sublingually, but if injected with opiates on board, it causes withdrawal and thus discourages injecting. Having said that, there is a lot of Suboxone on the street but, similar to methadone, it is mainly used to control addiction.

Summary of current issues:

1. OST debate polarised into buprenorphine 'good' v methadone 'bad'
2. Concern regarding dramatic rise in the prescription opiates – including injecting
3. Need to challenge the criminalisation of many people who use drugs

San Francisco – Dan Cicciarione

San Francisco is a different world from the rest of the US. The official drug policy in San Francisco is one of harm reduction, NSPs are publicly funded and are reasonably plentiful and operate drop in sites but also through vans. Services have developed to the point now where anyone can walk in and get 30 syringes and not exchange for dirty needles. People are very proud of the mobile van provider systems and of having overcome the bureaucracy to get the mobile services implemented. They are well attended and bring methadone out to the community. This initiative contributed greatly to overcoming stigma, as there is now an acceptance and recognition of the vans operating in the communities.

Primary care physicians do sign up to prescribe buprenorphine, but it is very slow. Stigma runs very deep on a cultural level in the US, and it has been slow in getting buprenorphine adopted as a treatment option, but it is growing. Another reason for the slow uptake is that the Drug Enforcement Agency forces physicians to go through an 8 hour course to prescribe a very simple drug (buprenorphine), and the licence to prescribe it has a tracking function so that the government can monitor the prescriptions that are issued.

San Francisco has been bold and clever about helping people with HIV, mental health and IDU problems to get integrated services. An example is the 'Open Doors' program where

people can come in as an active user, on medication, it caters for all groups, young people, gay people, sex workers, drug users – just about everyone in San Francisco. It is a true harm reduction site with a multi-disciplinary team: doctors, social workers, and nurses. This reveals the upside - that where groups have to go underground due to for example stigma, it also creates an identity.

The fact that San Francisco operates in this bubble is an issue. A lot of IDUs are interested in getting off and they can't, because there are long waiting lists, access is not easy, people become frustrated and drop off the waiting list.

San Francisco is similar to other parts of the US in one respect, that in general there is an approach of high morality towards drug users leading to stigmatisation. The War on Drugs is alive and well and there are still a lot of drug users being locked up. There is gravely inadequate funding. The larger health system is dysfunctional - if you are middle class and have insurance you can be helped, but otherwise there are those very long waiting lists.

Summary of current issues:

1. Inadequate funding
2. Criminalisation of drug users
3. Long waiting lists

Canada – John Farley

Dr. Farley is responsible for the HCV and HIV treatment in practices in corrections in the Pacific Region in Canada and has also had a private practice where he sees patients in the community – It is relatively easy in the Vancouver area where NSP is well provided for, but in the prisons there is no needle service provision, so infections occur in prison and nothing can done about it as far as treatment goes. They do a very good job with treating Hep C in the prison and SPR rates are as good as any published data, however, we have a relatively high likelihood of re-infection because people use drugs and they share dirty needles and nothing is done about that. So that is one of the areas where policy directly affects HCV infection rates - by not having these appropriate policies in the prison setting affecting HIV and HCV.

Another issue is continuity of care. Officially there is a policy of methadone being available in the prison setting, but there are so many hoops to go through because in prison it is no longer a health care issue, it is a safety and correctional issue and there are many considerations to take into account in making available methadone – for example who makes the decision for a person to get off OST.

Another problem is the crossing point between the Federal Institution, which is for the people who have a sentence of more than 2 years; and the separate facilities for those who are to serve a sentence of 2 years less a day. There is no coordination in policy between them, so inmates come from one facility to the next and there is a lack of continuity. These are just some of the challenges where having unified treatment policies would help. There is for example an inmate health integration service established in the community setting where clinicians like Dr. Farley will accept patients in the community from the prison. Referrals come from some distance from these services, because it is known that these patients are accepted there. It would help to get like minded physicians who indicate they are willing to take on these patients for a more integrated system, but there is no legislation governing this.

Summary of current issues:

1. No continuity of care between in community and prison
2. High rate of HCV
3. Rules governing doctors prescribing can be prohibitive. Need better coordination of care in prisons and in the community.

IDHDP Executive Team
April 2011