

**Drug and Alcohol Dependence  
Policies, Legislation and  
Programmes for Treatment  
And Rehabilitation**

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DRUG AND ALCOHOL DEPENDENCE:  
POLICIES, LEGISLATION AND PROGRAMMES  
FOR TREATMENT AND REHABILITATION

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DRUG AND ALCOHOL DEPENDENCE:  
POLICIES, LEGISLATION AND PROGRAMMES  
FOR TREATMENT AND REHABILITATION

A Comparative Survey of  
Existing Policies, Legislation and Programmes

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## 1. Introduction

The purpose of this study is to investigate the effects of the proposed system on the performance of the system. The study is divided into two main parts: a theoretical analysis and an experimental evaluation.

## 2. Theoretical Analysis

The theoretical analysis is divided into two main parts: a theoretical analysis and an experimental evaluation. The theoretical analysis is divided into two main parts: a theoretical analysis and an experimental evaluation. The theoretical analysis is divided into two main parts: a theoretical analysis and an experimental evaluation. The theoretical analysis is divided into two main parts: a theoretical analysis and an experimental evaluation.

## 3. Experimental Evaluation

The experimental evaluation is divided into two main parts: a theoretical analysis and an experimental evaluation. The experimental evaluation is divided into two main parts: a theoretical analysis and an experimental evaluation. The experimental evaluation is divided into two main parts: a theoretical analysis and an experimental evaluation.

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### Mario Argandoña

Mario Argandoña-Yanez, MD was Chief, Unit of Treatment and Care, Programme on Substance Abuse. Dr Argandoña was in charge of facilitating the work of Lane Porter and WJ Curran and was responsible for ensuring the accuracy of WHO technical papers and the legislation, policies and programmes reviewed for preparing this document. Dr Argandoña is now retired.

### William J. Curran

Before his death on 22 September 1996, William J Curran consulted with the head of the former Programme on Substance Abuse and the authors in the design of research for the survey study as well as the content of manuscript. As Director of the Harvard University - WHO International Collaborating Center for Health Legislation, Professor Curran drafted and circulated the survey instrument to key informants in the survey countries, reviewed early drafts of the document manuscript, and chaired the WHO Advisory Group Meeting on Policies, Legislation and Programmes on Dependence and Harmful Use of Drugs and Alcohol, held at Harvard University, 31 January – 2 February 1994. Professor Curran had a long and distinguished career in legal medicine, as Frances Glessner Lee Professor of Legal Medicine in the faculties of Harvard Medical School and Harvard School of Public Health. He addressed a comprehensive range of subjects in his "Law-medicine Notes" published in the *New England Journal of Medicine*. He drafted health legislation in Massachusetts in many areas, including mental health and substance abuse, and he co-authored *The Law and Mental Health: Harmonizing Objectives*, published by WHO in 1978, as well as co-authored the 1986 WHO publication *The Law and the treatment of drug-and alcohol-dependent persons*. Professor Curran was a mentor, wise counsel, and friend, who invited both his WHO colleagues and students to his residence not only for long days of

discussion to review draft manuscripts but also to participate in social and family gatherings. While his loss is profound both professionally and personally to those of us who were his students, friends and colleagues, his contributions and influence in legal medicine and health law continue to inspire and guide us.

Lane Porter, JD, MPH  
November 1999

## Preface

This document forms part of the World Health Organization's continuing review and analysis of legislation on health matters that are likely to be of interest to Member States. As an update and expansion of a 1986 WHO publication, *The law and the treatment of drug- and alcohol-dependent persons*, it reviews legislation on compulsory legal commitment, treatment associated with the criminal justice system, and reporting, registration, laboratory testing and community surveillance. It analyses national drug and alcohol policies and programmes for treatment and rehabilitation. It also reviews developments in several areas that were not covered by the previous publication, including legislation relating to human immunodeficiency virus (HIV) infection and the acquired immunodeficiency syndrome (AIDS) as well as to solvent abuse, and measures to combat discrimination and protect human rights.

During the preparation of this document, over 150 experts were consulted and provided information. Site visits were conducted in 10 selected countries. Guidance on the content of the survey was provided by members of a special advisory group (listed in Annex 1); the main and independent points of the advisory group member papers are presented, and indicated as such, variously throughout this document. In 1999, many governments provided updated information which has been integrated into the text, as of November 1999. See Section 1.3 (Methodology) for information on data collection. Legislative summaries stated in the *International Digest of Health Legislation* were reviewed to 1999 first quarter publication.

While prevention is recognized as an essential component of care for those who are dependent on alcohol and drugs, it is not covered here. Moreover, the document does not cover two other areas involving the law and substance abuse, namely drink-driving and the legal provisions surrounding welfare and custody of children.

On behalf of the World Health Organization, I thank all those who contributed to this work, and especially the authors, who had the daunting task of bringing together all the information. It is gratifying to acknowledge the continuity of longstanding interest and support within both the World Health Organization and Member States. In particular, I acknowledge the insight and dedication of Mr Hans Emblad, former Director of the Programme on Substance Abuse, who initiated this important work. Thanks are also due to the Government of Japan, which provided financial support for the survey.

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# 1. Background

## 1.1 Introduction

This document is concerned with ways in which the law can serve to create and maintain effective treatment and rehabilitation programmes for both drug- and alcohol-dependent persons. The main focus is on the results of a comparative survey of relevant policies, legislation, responses from key country level informants, site visits, and suggestions for alternative approaches to the development and review of national legislation in this field. It is concerned primarily with how legislation promotes the treatment and rehabilitation of persons who are dependent on either alcohol or drugs, or both. It concentrates on an analysis of the legal, administrative, scientific and clinical components of treatment and rehabilitation programmes. It is anticipated that, in the light of prior WHO studies and through comparative review of the policy, legislative and programme components, countries will be able to determine more effectively what changes, if any, are needed in these areas.

The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, adopted in 1988, is the major recent international treaty development in international efforts to control the illicit traffic in drugs, and national governments have begun the enactment of legislation implementing this Convention into national law. Together with the Single Convention on Narcotic Drugs 1961 (as amended by the 1972 Protocol) and the Convention on Psychotropic Substances, there are thus now three international conventions in this field. The United Nations Declaration of the International Conference on Drug Abuse and Illicit Trafficking and the Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control were published in 1988 (United Nations, 1988).

Each of the three international conventions noted above contain provisions on the treatment and rehabilitation of drug-dependent persons, which are considered one of several ways of reducing the demand for illicit drugs. The 1988 Convention requires countries which are signatories to its provisions to adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic. The 1988 Convention also provides that measures may be based on WHO recommendations and on the Comprehensive Multidisciplinary Outline referred to above, as it pertains to governmental and nongovernmental agencies and private efforts in the fields of prevention, treatment and rehabilitation. In its 1999 report (United Nations, 1999a) *Global Illicit Drug Trends*, published 1 June 1999 based on data obtained primarily from the annual reports questionnaires received by United Nations Drug Control Programme (UNDCP) up to February 1999, UNDCP noted that in adopting a Political Declaration, as well as a Declaration on the Guiding Principles of Drug Demand Reduction, the United Nations General Assembly at its twentieth special session emphasized the importance of a "balanced approach" (demand and supply on

equal status) but also noted that effective demand reduction activities could develop only through regular, objective and scientifically valid assessments of the drug problem. Consequently, the 1999 report now contains a statistical summary of the demand side data, obtained from annual reports, (United Nations, 1999a) intended to show one of the several ways in which UNDCP is trying to put in place the "balanced approach". As noted in the 1999 report, data on supply side indicators, such as illicit drug cultivation, has been collected and published on an organized basis for many decades. Indicators to measure the demand for illicit drugs, such as the treatment and prevention of drug abuse, have not received the same international attention. So, the 1999 report contains two parts: (i) supply; and (ii) demand (United Nations, 1999a).

Alcohol and substances liable to abuse other than drugs are not the subject of international agreements or conventions<sup>1</sup>.

The present document reviews national policies and legislation on needle exchange. It also reviews policies and legislation protecting the rights and welfare of drug- and alcohol-dependent persons. It examines legislation on treatment for solvent and inhalant use, but does not cover legislation on tobacco, which is the subject of other WHO publications.

It emerges from the present international survey that one of the major problems with regard to drug dependence is the difficulty of reconciling the policy objectives of law-enforcement agencies with those of treatment programmes. This is consistent with the findings of prior WHO surveys (Porter, Arif & Curran, 1986). Although each has its own legitimate interests in relation to the treatment or rehabilitation of drug- or alcohol-dependent persons, the aims of law-enforcement groups, welfare agencies, public health ministries, or specialized AIDS programmes, are not always in harmony. Over several decades WHO has given close attention to ways in which legislation can serve to resolve such conflicts and create and maintain effective treatment programmes for both drug- and alcohol-dependent persons. WHO is also interested in producing guidelines for assessing how existing legislation functions, and providing suggestions for alternative approaches to the development and review of national legislation.

The current survey has expanded the inquiry to include the analysis of official government policies concerning treatment and rehabilitation goals and objectives.

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<sup>1</sup> In May 1996, the World Health Assembly adopted a resolution called the World Health Organization To Develop an International Framework Convention for Tobacco Control in accordance with Article 19 of the WHO Constitution. Meeting in October 1999, a working group established a technical and scientific foundation for ministerial negotiations scheduled for 2000, and signatories in 2003 (World Health Organization, 1999a).

## 1.2 Purpose and scope of the survey

The purpose of the present survey is to describe and analyse existing policies, legislation and programmes on the treatment and rehabilitation of drug- and alcohol-dependent persons in selected countries and territories. This comparative review should help countries to determine what changes, if any, are needed in their policies, legislation and programmes.

Most of the analysis concerns legislation. Legislative analysis generally involves two tasks. Firstly, the text of the legislation must be examined carefully to determine its literal meaning and explicit objectives. Definitions of key terms, such as "drug dependence", and "alcoholic" are important in this regard. Secondly, it is important to determine whether the legislation facilitates or impedes treatment and rehabilitation programmes, and how such legislation is perceived by those who administer it, and deliver services pursuant to its provisions.

## 1.3 Methodology

While the survey questionnaire to key contacts in the countries resulted in detailed responses received primarily in late 1993, 1994, and 1995, the present international comparative survey reviewed selected national policies, legislative enactments, and programme documents up to November 1999. Where still in force, legislation included in the previous WHO survey (Porter, Arif & Curran, 1986) was reviewed, with amendments, and included in the current survey. We also reviewed other legislation (not summarized in Annex 2) relating to treatment, such as patients' rights laws, and legislation concerning AIDS. A list of the legislation mentioned in the book, by country or territory, can be found in Annex 3. Copies of legislation were obtained from the following sources:

- complete texts of legislation and summaries of such texts published in the World Health Organization , *International Digest of Health Legislation [IDHL]*;
- complete texts of legislation published by the United Nations Division of Narcotics Drugs (E/NL series);
- United Nations and national government legislative document repositories;
- personal communications from respondents to questionnaires in the countries and territories surveyed.

WHO documents and reports on drug and alcohol abuse were analysed, and United Nations reports and publications, especially on the international drug

conventions, reviewed. Various legal and health agencies and individuals were consulted. WHO collaborating centres specializing in drug and alcohol dependence were contacted and consulted. A general meeting of representatives of these collaborating centres was held in September 1993, resulting in guidance and site visit arrangements. Those responsible for drug and alcohol dependence in each of the six WHO regions were contacted; they made suggestions concerning the countries and territories which might be included in the study, identified key contacts, and helped in making site visit arrangements.

A survey questionnaire was distributed by the WHO International Collaborating Centre for Health Legislation at Harvard University to a comprehensive list of key contacts in the study countries. These included officials of government coordinating and advisory bodies; clinical directors of drug and alcohol treatment centres; heads of health ministries; drug or alcohol agencies; judges and lawyers and law-enforcement personnel; and academics specializing in substance abuse matters. Responses to survey questionnaires were received from over 150 persons.

Site visits were conducted in 10 selected countries<sup>2</sup> during the months of September to December 1993. Several factors, reviewed with regional offices, went into their selection, including the availability of key informants, extant or planned legislation on drug or alcohol dependence, proposals to change policies, legislation, or programmes, and treatment or rehabilitation facilities which could be readily observed. The 10 countries visited in 1993 were Brazil, China, Egypt, India, Mexico, South Africa, Sweden, Thailand, United States of America, and Zimbabwe. In summer 1999, governments of each country in the survey were contacted with a request for updated information on drug and alcohol policies and legislation. The results of the 1999 country responses have been integrated into the text, to the extent information was provided.

A total of 77 countries are included in the comparative legal survey of national and subnational legislation summarized in Annex 2. Information on policies and legislation from additional countries is also provided throughout this summary. The selection criteria include varying social, cultural and economic characteristics, established and emerging legislative systems, developing national policies, and varying patterns of health care services, economic development, and population size. It was recognized that it is no longer useful to distinguish between countries in which drugs originate and those in which they are abused. So-called "supply" countries are experiencing drug dependence in their populations, "demand" countries frequently produce their own harmful substances, and countries on transit routes often have drug

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<sup>2</sup> At the time of the 1993 site visits, Macao and Hong Kong were territories respectively of Portugal and of the United Kingdom, which became Special Administrative Regions of China, pursuant to bilateral agreements. Depending upon context, Hong Kong and Macao are described as "territories", periodically, in the text which follows or as "Special Administrative Regions".



abuse problems of their own. Several countries in the process of economic and political change are included (e.g. China, Czech Republic, Hungary, Kazakhstan, Latvia, Lithuania, Poland, Russian Federation, Slovakia, South Africa, and Ukraine). China was included in part because of the existence of agreements (China and United Kingdom; China and Portugal) under which Hong Kong<sup>3</sup> (in 1997) and Macao<sup>4</sup> (in 1999) became special administrative regions of China; requiring reconciliation of any conflicts in policies, legislation and practices between China and the former territories.

Some countries where the legislation is concerned significantly with the treatment of alcohol-dependent persons were included (e.g. Poland, Russian Federation, Sweden, Switzerland); as well as some where the major emphasis was on the treatment of drug dependence (e.g. Colombia, India, Japan). Included also were a few countries (e.g. Czech Republic, United States of America [Florida]) with legislation that contains provisions governing the treatment of both drug and alcohol dependence. Two countries (Mexico, Sweden) have enacted laws expressly for the treatment of abusers of volatile solvent inhalants. Several countries (e.g. Ireland, Kenya, Tonga) provide services for drug- or alcohol-dependent persons under provisions in mental health laws. A few countries (Finland, Norway, Sweden, Ukraine) with special social services legislation were included. We identified laws protecting the individual rights of persons in hospital and other settings, and some specialized legislation providing specific safeguards for drug- and alcohol-dependent persons. Legislation specifically for minors (children, youth, or juveniles) in several jurisdictions (e.g. Austria, China [Special Administrative Region, Hong Kong], Bolivia, Ecuador, Hungary, India, Indonesia, Italy, Malaysia, Mexico, Norway, Peru, Poland, Russian Federation, South Africa, Sweden, United States of America [Connecticut, Florida, Massachusetts]) was also examined.

In some countries (e.g. Bahrain, Poland) important changes in national legislation in the drug and alcohol fields were found to be in the process of development; these are noted in Annex 2, together with a summary of any legislation currently in force.

For countries with a federal structure it was not practical to include a review of the law in every state, province or canton; it was therefore decided that the legislation of at least one state or its equivalent in countries with a federal structure would be analysed.

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<sup>3</sup> See Chapter 2 (2.3) and Chapter 6 (6.2) for a discussion of the provisions governing Hong Kong's legal system after 1 July 1997, when Hong Kong (a former United Kingdom territory) became Hong Kong Administrative Region of China.

<sup>4</sup> See Chapter 6 (6.2) for a discussion of the provisions governing Macao's status after 20 December 1999 when Macao (a former Portuguese territory) became Macao Special Administrative Region of China.

The 77 countries included in the survey whose national and subnational legislation is summarized in Annex 2, by WHO Region, are shown in the box.

***African Region:*** Kenya, Mauritius, Nigeria, Senegal, Seychelles, South Africa, Zimbabwe.

***Region of the Americas:*** Argentina, Belize, Bolivia, Brazil, Canada (Federal British Columbia, Prince Edward Island, Nova Scotia), Chile, Colombia, Costa Rica, Ecuador, Mexico (Federal, Federal District), Paraguay, Peru, Trinidad and Tobago, United States of America (Federal, Connecticut, Florida, Massachusetts), Venezuela.

***Eastern Mediterranean Region:*** Afghanistan, Bahrain, Cyprus, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Pakistan, Qatar, Tunisia, United Arab Emirates.

***European Region:*** Austria, Czech Republic, Denmark, Finland, France, Germany (Federal, Bavaria), Greece, Hungary, Ireland, Israel, Italy, Kazakhstan, Latvia, Lithuania, Malta, Norway, Poland, Portugal, Russian Federation, San Marino, Slovakia, Spain (Federal, Catalonia), Sweden, Switzerland (Federal Geneva), Turkey, Ukraine, United Kingdom (England and Wales).

***South-East Asia Region:*** Bangladesh, India (Federal, Bihar), Indonesia, Myanmar, Sri Lanka, Thailand.

***Western Pacific Region:*** Australia (Federal, New South Wales, Queensland), China (Federal, Hong Kong, Macao), Japan, Malaysia, New Zealand, Papua New Guinea, Philippines, Singapore, Tonga, Viet Nam.

WHO has conducted and published the results of several international surveys of legislation relating to alcohol and drug dependence. The latest in this field was a survey of the law and treatment of drug- and alcohol-dependent persons, published by WHO in English in 1986 (Porter, Arif & Curran, 1986) and in French in 1988 (Porter, Arif & Curran, 1988). Guidelines for assessing and revising drug-and alcohol-

treatment legislation were published by WHO in 1987 (Curran, Arif & Jayasuriya, 1987). These publications are cited frequently in this book.

A meeting of a WHO Advisory Group concerned with the present study was held at the WHO International Collaborating Centre for Health Legislation at Harvard University on 31 January to 2 February 1994. The participants (see Annex 1) presented papers<sup>5</sup> on subjects covered in this publication, confirmed the approach adopted in the study, and reviewed initial draft sections. A draft of the study was completed for review in August 1995 and circulated to Advisory Group members, staff members at WHO headquarters, officers responsible for substance abuse in the WHO regional offices, the United Nations Drug Control Programme in Vienna, and selected country-level experts. After review and comment, a final text was prepared for publication.

The information in the current publication is presented in 15 chapters, references and six annexes. The results of the survey of legislation are integrated throughout the narrative text; and summarized in Annex 2. The legislative summaries in Annex 2 are grouped together under three headings, as follows: (1) compulsory civil commitment [A2.1]; (2) treatment associated with the criminal justice system [A.2.2]; and (3) compulsory reporting, central registries, laboratory testing and community surveillance [A2.3]. The results of the survey of official government drug and alcohol policies on treatment and rehabilitation (available to WHO) are reviewed in Chapter 7 and variously throughout the document. A list of legislation reviewed is presented in Annex 3. Annex 4 summarizes the opinions of survey respondents on whether legislation facilitates or hinders the development of treatment programmes and suggestions for further reading are given in Annex 5, the bibliography. In addition, a series of tables and lists are interspersed throughout the chapters in order to present the information in a simple, easily readable form. As recommended by the 1994 Advisory Group, information generated from site visits and other sources is also presented in the various chapters of the book.

## **1.4 Previous WHO studies and reports**

The present study brings up to date the WHO comparative survey of *The law and the treatment of drug- and alcohol-dependent persons*, published by WHO in English in 1986 (Porter, Arif & Curran, 1986) and in French in 1988 (Porter, Arif & Curran, 1988). The most important and relevant of the earlier WHO publications and reports are summarized below in chronological order from 1955 onwards. WHO Technical Reports on treatment and rehabilitation are dealt with separately in Chapter 3.

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<sup>5</sup> The main and independent points of the Advisory Group members are presented, and indicated as such, variously throughout this document.

#### 1.4.1 *WHO Expert Committee on Mental Health: fourth report (1955)*

WHO has paid considerable attention in the past to national legislation on mental health, as well as drug and alcohol dependence. Thus the fourth report of the WHO Expert Committee on Mental Health, *Legislation affecting psychiatric treatment* (World Health Organization, 1955), emphasized that "the principles governing good psychiatric legislation arise out of the need both for adequate mental health services and for care of the patient and the protection of society". The report specifically mentioned the need for legislation that authorized compulsory treatment for alcoholics who were dangerous to themselves or others, but not for all patients suffering from alcohol dependence.

#### 1.4.2 *Survey of legislation on treatment of drug addicts (1962)*

In 1962, WHO prepared and published its first survey of existing legislation on the treatment of drug addicts (World Health Organization, 1962a). This survey pointed out that, in some areas, individual clinical treatment was not feasible because of lack of facilities and professional manpower, and that the only alternative was to take more active measures directed primarily against sources of supply of narcotics. Even where official figures showed a low rate of drug addiction, many countries (e.g. Norway) nevertheless considered it to be a serious public health problem. It was noted in the survey that public attitudes varied in different sociocultural contexts, with the result that in some countries severe penalties for addiction were considered appropriate whereas in others a "habit" was considered "normal". Attitudes were found to be changing, however, leading towards the recognition that the drug addict was above all a sick person in need of suitable and effective treatment and rehabilitation. It was pointed out that drug addicts do not usually show marked criminal tendencies, but that the need to obtain supplies of narcotic drugs often leads them to commit breaches of the laws relating to traffic in such drugs. In the judicial systems studied, there was a tendency to resort to social aid instead of routinely imposing the prison sentences authorized by law for such offences. Subject to the consent of the addict and to certain specific conditions, therefore, addicts were not sent to prison but instead medical treatment (i.e. diversion from the criminal justice system) was ordered.

The 1962 study reported that the laws surveyed generally allowed for lengthy treatment, that the consensus of opinion among most of the commentators recommending commitment was that, in order to prevent relapses, the treatment must be of long duration (i.e. for two or three years), and that the period allotted for rehabilitation and psychotherapeutic care should also be of prolonged duration, followed by rigorous supervision in order to prevent possible relapses after discharge.

In the majority of countries surveyed in the 1962 report, legal provisions regarding treatment and hospitalization of drug addicts were included in legislation relating either to the treatment of mental patients or to traffic in narcotic drugs. Mental

health legislation had been enacted in Brazil, Canada (province of Saskatchewan), the Federal Republic of Germany (in various *Länder*) and in Switzerland (the cantons of Neuchâtel and Vaud), while legislation on the control of drug traffic was found in the Dominican Republic, Egypt, Greece, Guatemala, the Islamic Republic of Iran, Italy, Morocco, Panama, the United Kingdom, Venezuela, and Viet Nam. A more unusual type of legislation was found in Australia (Western Australia), Finland, and Norway, where legal provisions relating to the treatment of alcoholics had been amended or adapted to include measures appropriate to the treatment of drug addicts.

Some countries included in the survey had no specific legal provisions on the subject, since the authorities considered that cases of abuse of narcotic drugs were so few in number that special legislation was unnecessary. In these countries, the mental health laws were available for mentally ill drug abusers.

The majority of the legislative texts reviewed in the 1962 study had been enacted after 1945. Among the few earlier enactments were those of Brazil (1934), Switzerland (cantons of Neuchâtel, 1936 and Vaud, 1939) and Venezuela (1934).

The great majority of the legislative provisions considered did not contain any legal definition of a drug addict, but exceptions to this rule were found in the legislation of Canada (Saskatchewan) and the United States of America (District of Columbia). In Saskatchewan, the addict is defined as being "a person suffering from a disorder or disability of mind as evidenced by his being so given over to the use of alcohol or drugs that he is unable to control himself or is incapable of managing his affairs, or endangers himself or others". In the District of Columbia, a "drug user" was defined as "a person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety or welfare, or who is so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction". The 1962 survey emphasized that it was difficult for public health authorities to track down drug addicts or keep up to date any register of such persons unless there was a system of notification. In many countries, however, notification was not compulsory and information was therefore not uniformly reliable. The 1962 survey included a review of laws governing standards and procedures for compulsory commitment for treatment. Provisions for such compulsory commitment were found in many countries, while in others, voluntary treatment was preferred.

#### 1.4.3 *WHO Expert Committee on Mental Health: fourteenth report (1967)*

The fourteenth report of the WHO Expert Committee on Mental Health was published in 1967 (World Health Organization, 1967) and brought together WHO policies and programmes for the prevention and treatment of dependence on alcohol and drugs. Similarities and differences in causation and treatment were carefully analysed. The report considered: (a) an approach to problems of dependence on

alcohol and other drugs; (b) treatment services; (c) education and training; and (d) research. In conclusion, a number of recommendations were made, two of which are of special significance:

- Legislation on persons dependent on alcohol or other drugs should recognize that such persons are sick. Medical and public health experts should be involved in formulating such legislation.
- Adequate treatment and rehabilitation should, if necessary, be ensured by civil commitment of drug-dependent persons to the care of the medical authorities, who should direct and supervise such care, from initial diagnosis to rehabilitation.

The Committee also suggested that research should be carried out on a number of topics, one of which was a comparison of legislative and other measures for the control of drugs and the treatment of drug-dependent persons, including the enforcement of such measures, and a study of their possible effects on the extent and pattern of drug abuse.

#### 1.4.4 *Study on the law and mental health (1977)*

A report on harmonizing objectives in law and mental health was published by WHO in 1977 (Curran & Harding, 1977). This is concerned with ways in which law can be used to promote more effective and humane responses to mental disorders, and contains guidelines for use in assessing how existing legislation functions as well as alternative approaches to improving legislation. It was hoped that the report would stimulate legislative review at the national level and generate new approaches and creative drafting in future legislation.

Much of the report is concerned with evaluating national mental health legislation, its origins and development, and subsequent interest in changing the legislation. The various hospitalization procedures are reviewed and the trend towards voluntary care analysed. Attention is given to programme administration and the legal differentiation of mental disorders.

The report contains a summary of the legal provisions of 43 countries governing voluntary access to care, involuntary hospitalization, emergency hospitalization, and observational hospitalization. These procedures were compared against the background of information received in response to a questionnaire. Indicators were identified for use in examining the legislation. It was considered important to encourage the development of mental health legislation that is in harmony with the needs of mental health programme operations, policy, and objectives. Examples of legislation that accomplished this objective were sought.

Certain themes were identified and there appeared to be agreement on the following requirements:

1. Mental patients should be handled as much like other medical patients as possible, thus removing the stigma associated with special treatment.
2. Treatment should be provided on a voluntary basis if at all possible and involuntary measures used only as a last resort and in emergencies.
3. It is important that all special legal "labelling" of the mentally retarded should be abolished; they should receive proper education and habilitation in the same manner as other citizens.
4. Mental health programmes should be integrated into general health and social services, particularly at the point of delivery in hospitals and in the community.

Legislation on drug and alcohol dependence was not reviewed in the 1977 report except in the overall context of national mental health legislation. The 1986 survey (see section 1.4.6) and the current study are intended to complement and expand on the earlier work on the comparative analysis of mental health laws and should add an important dimension. We found parallel concerns for the problems of stigma associated with drug and alcohol dependence and for the integration of drug- and alcohol-treatment programmes into general health and social services.

#### *1.4.5 Study on sociocultural aspects of drug problems (1980)*

This study (Edwards & Arif, eds., 1980) involved 40 investigators from different countries, and covered many important aspects of the drug problem, including epidemiology, patterns of drug abuse, health-care approaches, and treatment and prevention policies and strategies.

Different health-care approaches to the management of drug dependence are presented, and it is emphasized that sociocultural considerations are important in selecting the one most likely to achieve the desired results; such considerations have a definite bearing on the difficulty a drug user may experience in giving up the habit.

A number of case studies are presented to illustrate how different countries have approached this problem. While it is possible to extract certain general principles from these experiences, there is no master strategy that will be applicable to all

situations; the aim must be a flexible response that combines elements of the various strategies in accordance with local needs.

The practical conclusions of this wide-ranging study are brought together in a discussion of questions of policies and programme planning. The essential principles of such planning are described and an attempt is made to show how sociocultural awareness can be applied in practice when formulating policies and devising programmes, and to offer explicit, rational guidelines.

#### **1.4.6 *Survey of law and treatment of drug-and alcohol-dependent persons (1986)***

This survey (Porter, Arif & Curran, 1986) covered legislation on the treatment of drug- and alcohol-dependent persons in 51 jurisdictions of 42 countries and one territory (Hong Kong). The survey reviewed legislation providing for compulsory civil commitment to treatment services for both drug- and alcohol-dependent persons. Compulsory civil commitment provisions were found in the following five categories of legislation: (1) general mental health legislation; (2) mental health legislation specifically mentioning drug or alcohol dependence; (3) special civil commitment legislation on drug dependence; (4) special civil commitment legislation on alcohol dependence; and (5) combined approaches covering both drugs and alcohol. Grounds for civil commitment varied widely, depending on several factors, including the type of legislation containing the provisions. Provisions governing medical examinations (found in 24 of the 27 countries with compulsory civil commitment legislation) were reviewed. In general, it was found that such examinations must be conducted by one or more medical practitioners, and only rarely is it specified that they must be psychiatrists. Examination of the provisions governing length of stay and periodic review of treatment revealed an extremely wide range of treatment duration (ranging from not more than eight hours to a term of up to 10 years) related primarily to the type of treatment, e.g. short-term emergency as opposed to long-term residence for drug dependence associated with mental illness. Periodic review was conducted by a variety of bodies and individuals (e.g. boards, commissions, government offices).

Legislation on diversion to treatment from the criminal justice system was analysed in 22 (of 51) jurisdictions. Such diversion could take place at one or more of three stages in the criminal justice process: (1) treatment pending or in lieu of trial (pre-trial diversion); (2) treatment in lieu of imprisonment; (3) treatment concurrent with sentence.

In addition, legislation on compulsory notification, central registries, laboratory testing and community surveillance was reviewed.

Summaries of legislation of the types noted above were given in a uniform format in an annex.



The publication also set out the basic principles of legislation on drug and alcohol dependence (covering working with legislatures; evaluation of legislation; review mechanisms; development of legislation; criteria for legal provisions; entry into treatment, diversion to treatment from the criminal justice system; confidentiality; and links with other health services).

An advisory group met on two occasions at Harvard University to review drafts and guide the progress of the study in 1986.

The present international survey closely follows the procedural approach adopted in the 1986 study of the law and the treatment of drug- and alcohol-dependent persons (and in the 1977 survey of mental health law) and is structured in a similar fashion. This uniformity of format, procedure, and analysis should facilitate comparative review as well as further and more detailed analysis of legislation on substance abuse.

One of the recommendations of the 1986 survey was that legislative guidelines should be developed that could be used by WHO Member States in the drafting of new legislation.

#### *1.4.7 Guidelines for assessing and revising national legislation on treatment of drug- and alcohol-dependent persons (1987)*

WHO published, in 1987, guidelines for assessing and revising national legislation on treatment for drug- and alcohol-dependent persons (Curran, Arif & Jayasuriya, 1987). The guidelines thus met the need identified in the 1986 WHO legislative survey. Intended for use as a practical guide for the improvement of national legislation on treatment programmes, they were designed to take due account of each individual country's needs, resources, and culture. For this reason alternative approaches were described so that Member States could select those most appropriate to their particular conditions.

An advisory group considered a series of recommendations with regard to further activities and research in the field, summarized as follows:

1. The highest priority as far as further research is concerned should be given to actual field studies in selected Member States on the effectiveness of various legislative approaches to solving drug- and alcohol-treatment problems.

2. Studies of the effectiveness of such legislation should be focused on the following:
  - (a) procedures for diversion from the criminal justice system for the specialized treatment of drug and alcohol dependence;
  - (b) voluntary treatment, especially for drug dependence;
  - (c) specialized treatment in prisons.
3. High priority should also be given to programmes for alcohol impaired automobile drivers, where special legislation is needed to make such programmes feasible.
4. Attention should be given to research on the structure and usefulness of national coordinating bodies for all aspects of drug and/or alcohol control, including prevention, treatment, rehabilitation, agricultural control and education.
5. Special research should be conducted on the legal issues involved in ensuring confidentiality for patients, and in providing protection for professional therapists from unfounded lawsuits concerning treatment and treatment decisions.
6. National policies in the development of drug and alcohol programmes should be coordinated with periodic reviews and updating of the national drug and alcohol legislation.

#### 1.4.8 *The uses of methadone in the treatment and management of opioid dependence (1989)*

This report (Gossop, Grant & Wodak, 1989) is based on the results of a WHO meeting on this subject in which the use of methadone in the treatment of opioid dependence was examined and issues, problems and experiences in a number of countries reviewed. It was observed that the substitution of legal opioid drugs for illegal ones dates back over a century, and that methadone is the most common substitute drug used. It is widely used in many countries in the treatment of dependence on heroin and other opioids. It is important to distinguish between the uses of methadone in detoxification and its use as a substitute or maintenance drug. The practice and pattern of methadone use is related to many factors, including the nature of the national drug problem, experiences of any adverse effects of methadone, value orientation and ideologies. In many countries methadone maintenance has been considered to be an important element of a comprehensive response to injecting drug

use. One of the most important and threatening developments which revived interest in the use of methadone as a substitution drug has been the appearance and spread of HIV infection among injecting drug users. The participants noted evidence that this reappraisal had already begun in some countries as a result of the rapid spread of heroin problems and criminal behaviours prior to the identification of the linkage between drugs and HIV infection.

Several observations were made concerning law, the control of methadone, and treatment approaches. An analysis of legislative changes in some countries suggested to the participants a pendular movement of policy in which there was a swing back and forth between "repressive" measures and medical priorities. Restrictions often follow the identification or perception of unintended consequences associated with earlier liberal methadone prescribing policies, while the awareness that large numbers of opioid-dependent persons are outside the treatment system has often led to calls for easier access to methadone maintenance programmes and a desire to attract larger proportions of the dependent population into treatment. Changes in the characteristics of opioid abusers and the size of the dependent populations have also been reflected in the frequent changes in the regulations of many countries. Moreover, it was observed that no country had introduced legislation which requires compulsory admission to maintenance programmes. The participants noted that, at that time, all countries which provided methadone maintenance programmes did so on a voluntary basis. However, the criminal or narcotic laws in many countries contain provisions making it possible to suspend a sentence and to refer the drug-dependent person to a treatment programme. If the treatment is not followed, or otherwise fails, the sentence is reinstated. Methadone maintenance programmes are then one of the treatment modalities regarded as an acceptable alternative to imprisonment, but only if the drug-dependent person accepts the treatment option.

#### **1.4.9 *WHO Expert Committee on health promotion in the workplace (1993)***

A report on a meeting of a WHO Expert Committee (World Health Organization, 1993a) held in 1991 reached several conclusions of relevance. Training programmes on health promotion in the workplace covering the prevention, identification and treatment of alcohol- and drug-related problems, as well as the rehabilitation and social reintegration of affected workers, should be organized for professionals in occupational health and safety and personnel management and for representatives of employers' and workers' organizations. Governments should incorporate health promotion concepts and objectives into national programmes to be implemented both by health agencies and by those not exclusively concerned with health.

#### **1.4.10 *Assessing the standards of care in substance abuse treatment (1993)***

A report on schedules for the assessment of standards of care in substance-abuse treatment was issued in 1993 (World Health Organization, 1993b). The aim of these schedules is to provide guidance in assessing the adequacy and range of services provided for substance-abusers in order to bring about improvement in the quality of treatment. The five schedules cover intoxication and overdose; withdrawal symptoms; treatment and management techniques for dependence; physical complications of drug and alcohol abuse; psychiatric co-morbidity of drug abuse; and psychosocial disabilities.

#### **1.4.11 *WHO Expert Committee on Drug Dependence: twenty-eighth report (1993)***

In its twenty-eighth report, the WHO Expert Committee on Drug Dependence (World Health Organization, 1993c) noted that, since 1949, it had been given the task of evaluating individual psychoactive substances and recommending appropriate control measures. It also noted that, at its thirteenth meeting (World Health Organization, 1964b), it had decided to abandon the terms "drug addiction" and "habituation" in favour of "drug dependence" and that its terms of reference had been expanded to include all technical matters related to drug dependence. Subsequently, at its twentieth meeting in 1973 (World Health Organization, 1974), the Committee had discussed a wide range of topics concerning problems related to the non-medical use of psychoactive substances. Since 1973 the international drug situation had changed dramatically. The use of illicit drugs such as heroin and cocaine had increased by a factor of 10 and there had been increases in the harmful use of illicit drugs and alcohol, especially in developing countries. The emergence of the human immunodeficiency virus (HIV) leading to the acquired immunodeficiency deficiency syndrome (AIDS) pandemic had occurred during the decade of the 1980s. The use of psychoactive drugs had facilitated the spread of HIV infection in several ways, e.g. through needles shared by injecting drug-users, and through sexual contact by drug users engaged in prostitution in order to enable them to purchase psychoactive drugs. Moreover, alcohol and other psychoactive drugs were regarded by the Committee as disinhibitors so that, under their influence, many engage in sexual and other high-risk behaviours that they might otherwise avoid. The Committee considered: (a) drug-related problems and patterns of use; (b) approaches to prevention; (c) treatment responses to the harmful use of psychoactive substances; (d) research and evaluation; and (e) the need for an integrated national policy on psychoactive drugs. A number of recommendations were made, ten of which are of special significance to the current survey:

1. The development of treatment services for drug-related problems should be integrated with that of the mental health services, and the primary and general health services, and

resources allocated accordingly to maximize their effectiveness. For instance, many activities relating to prevention, treatment and follow-up are best carried out in a primary care setting.

2. To the extent possible, demand-reduction programmes should be based on a comprehensive approach to all potentially harmful psychoactive drugs. Thus attention must be paid not only to illicit drugs, but also to alcohol and tobacco, medicinal psychoactive drugs and volatile solvents to ensure that a reduction in health problems due to illicit drug use will not offset by an increase in problems due to the use of other drugs. WHO should collect and disseminate information in this area.
3. Intersectoral collaboration needs to be encouraged. The sectors involved will vary between countries, but will probably include a wide range of government agencies, nongovernmental organizations, community organizations, and the community itself. Achieving policy goals in this area will also require collaboration between health and non-health sectors, as well as between the public and private sectors. WHO should draw attention to successful intersectoral collaborative efforts that might serve as models.
4. The relation of the terms and definitions used in the international drug control conventions and procedures to present-day public health terms and concepts should be studied.
5. WHO should assist its Member States in strengthening their treatment services for drug-users. Such services should regard treatment as a long-term process that seeks to motivate, enable or empower the individual concerned to deal constructively with his or her own problems.
6. WHO should encourage the development of treatment programmes that are responsive to the complete range of needs of individual drug-users and their families.
7. Treatment services for drug-users can exist and operate properly only within a community context. Such services need to inform the community about what treatment is and what it seeks to achieve, so that drug-users are encouraged to seek help and the stigma associated with treatment is removed. They should also assist the reintegration and rehabilitation of treated drug-users in the community. Although treatment services should be based

on primary care, they should also collaborate with other community-oriented services and specialist services.

8. WHO should support its Member States in developing treatment services that can reduce the transmission of HIV through needle sharing or sexual activity among drug-users.
9. The primary goal of national demand-reduction programmes should be to minimize the harm associated with the use of alcohol, tobacco and other psychoactive drugs. The ultimate goal of these programmes will be to prevent all such harm; however, in the early stages of their implementation, the goal may be to reduce the harm to society. While some countries may decide to aim for complete eradication of the use of a particular drug, others may see such an aim as impractical or even undesirable. The Committee recommended that, for maximum effectiveness, national policies should be oriented to explicitly define "harm-minimization" goals, with both short-term and long-term objectives.
10. WHO should review ethical and human rights issues relating to the status of drug users, their families and others who may be affected by drug use, and encourage appropriate action by its Member States on such issues. Particular attention should be paid to issues raised by compulsory treatment, the protection of rights within the penal system, data protection, rights of access to treatment and social assistance, child custody, the implications of drug testing in the workplace, and the protection of research volunteers.

In its twenty-eighth report, the WHO Expert Committee on Drug Dependence (World Health Organization, 1993c) also recommended that WHO should promote research directed at exploring the feasibility and consequences of programmes that divert those arrested for drug misuse from the penal system to the health-care system.

#### **1.4.12 *WHO Expert Committee on Drug Dependence: twenty-ninth report (1995)***

In its twenty-ninth report, the WHO Expert Committee on Drug Dependence (World Health Organization, 1995a) concluded that strategies for combating drug abuse and illicit traffic would necessarily involve developing treatment and rehabilitation regimes as a major component of a comprehensive demand-reduction strategy. Such strategies would also involve the collaboration and cooperation of national governments and of international and intergovernmental organizations with relevant

expertise in this field. WHO's mandate on matters of international health confers on it the leadership role in assisting national governments that lack experience and expertise in the treatment and rehabilitation of drug-dependent persons. In that connection, WHO should develop a full range of cost-effective treatment and rehabilitation programmes. It is therefore envisaged that WHO will initiate the development of guidelines for the treatment and rehabilitation of drug-dependent persons as a form of assistance to national health authorities in their efforts.

### **1.5 United Nations General Assembly Political Declaration and Global Programme of Action for international cooperation in the control of drug abuse and illicit trafficking in narcotic drugs and psychotropic substances**

In 1990, the United Nations General Assembly took important action to coordinate international activities on drug abuse by adoption of the *Political Declaration and Global Programme of Action for international cooperation in the control of drug abuse and illicit trafficking in narcotic drugs and psychotropic substances* (United Nations, 1990a). This stated (in part) that:

- States and the United Nations, in United Nations' regional coordination, shall provide advice and legal technical assistance to enable States, at their request, to adapt their national legislation to international conventions and decisions dealing with drug abuse and illicit trafficking (paragraph 75).
- National strategies in the health, social, legal and penal fields shall contain programmes for the social reintegration, rehabilitation and treatment of drug abusers and drug-addicted offenders (paragraph 30).
- Training programmes relating to the latest developments and techniques in the field of treatment of drug addiction and rehabilitation and reintegration of former addicts must be conducted more regularly at the national, regional and international levels (paragraph 33).
- The United Nations shall act as a clearinghouse for information on effective policies and techniques, programme modalities and resource materials for the treatment, rehabilitation and occupational reintegration of former drug addicts. The World Health Organization and the International Labour

Organisation, in collaboration with other organizations of the United Nations system and nongovernmental organizations, shall be encouraged to contribute to that end (paragraph 31).

- The World Health Organization shall be encouraged to work with Governments with a view to facilitating access to drug-treatment programmes and to strengthening the capacity of primary health care to respond to drug-related health problems (paragraph 34).

The General Assembly Declaration is important in three main respects. It confirms the role of WHO in facilitating access to drug treatment, particularly in primary care services, as essential to effective drug control. It confirms the need for the establishment of linkages among the health, legal, social and criminal justice fields in national strategies. It emphasizes the need for Member States to receive necessary legal advice and training, which are essential if national legislation is to be brought into line with the international conventions.



## 2. Recent developments

### 2.1 Progress in scientific and clinical research<sup>1</sup>

#### 2.1.1 *New drugs of abuse*

The most discussed development of the last 10 years has been the proliferation of chemical analogue drugs C the so-called designer drugs. There has been much international and national legislative activity in this area, in an attempt to control what has not even been thought of yet, but designer drugs have not become an important presence on the mass illicit market anywhere (United Nations, 1997). On the one hand, this may be viewed as a success for the control regime but, the experience of recent years has shown that materials much more readily at hand, in most cases outside the existing international control structure, have been most successful on the illicit market.

Perhaps the three most significant trends, in an international perspective, have been: (1) the emergence of steroids and other performance-enhancing drugs as drugs of abuse; (2) the increase in the use of volatile solvents, particularly in marginalized populations; and (3) the spread of crack cocaine. The use of drugs as performance enhancers is by no means new, of course. Armies have long provided stimulants and analgesics to their troops in wartime, long-distance truckers with schedules to keep have long used amphetamines, and writers have long imagined that alcohol or opium or some other drug enhances their creativity. What is largely new is that this use of drugs, not for recreation, excitement or solace but rather in instrumental ways, has "come out of the closet", become a topic of open discussion and thus both a source of emulation and a politicized problem. The effects have been seen mainly in competitive sports, but drug abuse in this context has a number of special features. Steroid use in sports gives rise to concern, not only because of the potential harm to the steroid user and those around him or her, but also because it is seen as giving an unfair advantage in competition (Dubin, 1990; Lin & Erinoff, 1990; World Health Organization, 1993j). The elaborate international regimes which have grown up around drug testing in sports are primarily motivated by this concern for fairness in competition, a concern that differs from the usual concerns about the individual and social harms resulting from drug use.

The spread of crack cocaine (Reinerman & Levine, 1997) is an example of a phenomenon well known to those who market legal commodities: the repackaging and repositioning of an existing product. The chemistry required to transform cocaine into

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<sup>1</sup> Participants at the 1994 Advisory Group meeting at Harvard University addressed recent developments in scientific and clinical research affecting the alcohol- and drug-treatment systems in various countries. Sections 2.1.1-2.1.4 reflect the main points of a paper presented by Dr Robin Room at this meeting (R. Room, unpublished observations, 1994a, as amended).

crack is available in any kitchen. There may be an object lesson here: while the attention of the control system is focused mainly on high-technology designer drugs, the most successful drugs on the illicit market tend to be either unprocessed agricultural products or drugs produced by simple chemical transformations of such products.

As to the increase in glue, petrol and other solvent sniffing (Brady, 1992; Kozel et al., 1993), it is not always clear how much of this increase is real and how much is simply the result of the increased attention being given to the problem. In some specific circumstances, solvents are the most significant or the second most significant drug of abuse. This is true, for instance, of Australian aborigines and of aboriginal Canadians, particularly in rural areas, and it is often said to be true also of Mexicans, particularly poor Mexicans. A common pattern, shared by these areas, is for alcohol to be the main adult drug of abuse and solvent abuse to be the main problem among teenagers. It is perhaps a mark of modern civilization's dependence on petrol that there have been no very effective efforts to control its supply, apart from the armour plating of petrol pumps and fuel tanks in parts of the Australian outback. There has, however, been one effective, if unintentional, harm-reduction measure, namely the removal of lead compounds from petrol (Brady, 1992).

Despite an enormous investment, there has been little change in the last 10 years in the practical inventory of pharmacological aids in drug treatment. Perhaps 10 years from now practical therapies will begin to emerge from receptor research and genetic identification studies. In the meantime, the main innovations have been in drug-delivery systems, and have been rather simple mechanical and technological innovations. Long-acting methadone will raise in acute form the question whether the effectiveness of methadone maintenance is mainly the result of the drug itself or of having to come to the clinic every morning and the opportunities for other services which this opens up. Perhaps the most important pharmacological innovation has been the development of pharmacological means for quitting cigarette smoking, namely nicotine chewing gum, and more recently the patch (Ferrence et al., forthcoming). These treatments have an importance extending beyond their direct effects in saving the smoker's lungs; they have brought the treatment of tobacco dependence into everyday clinical practice, giving the doctor something that he or she feels comfortable doing. As such, they are part of the long march of tobacco smoking from being a matter of personal habit to becoming a drug of dependence and abuse.

### 2.1.2 *Epidemiological studies*

It might be said that there used to be two types of alcohol and drug epidemiology: clinical epidemiology, concerned with the demography and other characteristics of populations in treatment, and population epidemiology, concerned with patterns of alcohol and drug use and problems in the population at large (Caetano, 1991). In recent years, however, the gap between the two types of epidemiology has begun to close and a new epidemiology to develop a kind of social ecology of

treatment: how and under what circumstances alcohol- and drug-users enter particular types of treatment, and how a particular treatment episode fits into the drug-use career and the life cycle (Weisner, 1991).

Very little treatment is completely voluntary, in the sense that the user just decides by himself or herself to enter the treatment system but, on the other hand, most of the social control of alcohol and drug use is not the work of either the criminal justice system or the treatment system. Far more widespread, and far more common, are the comments and suggestions and control efforts made by family members and by friends and workmates (Room, 1989). Entry to treatment which is not legally coerced is usually the culmination of a long process of unsuccessful or partly successful efforts at social control by family and friends. No government has the resources to provide a treatment system which reaches as widely as the network of family and friendship relationships, and those who end up in formal treatment are usually only a small fraction of those who have been subject to these informal social controls.<sup>2</sup> For a number of reasons, cost being only one of them, it would be advisable to frame treatment legislation and criminal law so that they strengthen rather than underrate the network of family and personal relationships which is the most important social control on harmful drug use.

Research suggests that there are negative aspects of linking the alcohol- and drug-treatment system too closely to the criminal justice system. In the United States this link is very strong. Nearly everyone entering the public drug-treatment system in the United States does so under court pressure, and this is also becoming true of the public alcohol-treatment system. The criminal justice system is a potentially endless source of alcohol- and drug-related cases; it processes far more cases than the alcohol- and drug-treatment system (Weisner & Schmidt, 1995), but it is far from clear that the cases which it provides are amenable to treatment. Furthermore, too close a connection to the criminal justice system places substantial constraints on alcohol and drug treatment. Thus a problem with diversion to treatment from the courts in the United States is that the courts want the treatment to last longer than the jail sentence would have lasted: if treatment is seen as a softer option than jail, it should at least last as long as jail. This potentially makes treatment very expensive<sup>3</sup>. It is also in conflict with a main finding in the next area of research to be mentioned: treatment-outcome studies.

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<sup>2</sup> Some governments do in fact put resources into strengthening these informal healing efforts in the "open-community approach", e.g. in Sri Lanka (see section 4.2.3).

<sup>3</sup> See Section 2.4.2 for a discussion of the operation of drug courts in the United States; noting that "over 70 per cent of adult drug court participants stay in treatment".

### 2.1.3 *Treatment-outcome studies*

In the last 10 years, the literature on alcohol treatment outcome, in North America and other English-speaking countries, at least, has painted into a fairly consistent picture. All treatment does a little good, but the chances are only modest that a particular case will benefit from a particular treatment episode. There is therefore an urgent need to educate both the criminal justice system and policy makers, and to abandon the pretence that treatment potentially offers a permanent "cure"; relapses are to be expected and indeed planned for. While this is more contentious, there is only limited evidence that one treatment modality is better than another. This unpalatable finding has set off a search for a paradigm of "treatment matching", where clients are sorted by what treatment is most appropriate and helpful for them, but there is little evidence yet that any research-derived algorithm will give better results than those achieved by offering the client his or her choice from a menu of treatments (Project MATCH, 1997).

One main implication of the general finding that all treatments work a little and all work to much the same degree is that treatment resources are better spent on less intensive treatment of more cases than on more intensive treatments of fewer cases. This research finding has led to a shift both towards briefer alcohol treatment and towards outpatient treatment in such countries as Australia, Canada, and the United Kingdom. The same is true of the United States, where fiscal issues of cost containment have also played a role (Room, 1997). As mentioned above, this shift tends to run counter to the preferences of those staffing the criminal justice system, whose sense of natural justice wants to see even the diverted criminal inconvenienced for a considerable period of time. How this situation will develop in the United States, where the trend is towards increased court coercion in the public alcohol-treatment system, remains to be seen.

This review has so far been concerned only with the research literature on alcohol treatment outcomes. The literature on drug treatment outcomes is quite different, and it is time for these differences to be resolved. As can be seen from recent reports by the United States Institute of Medicine (Broadening the Base of Treatment for Alcohol Problems: Report of a Study by a Committee of the Institute of Medicine (Institute of Medicine, 1990; Gerstein & Harwood, 1992), it is taken for granted that frankly coerced treatment is effective in drug abuse while the same is not true for alcohol abuse. Given that most drug treatment in the United States is provided under court diversion or court pressure, the trend towards briefer treatments and more outpatient-based treatment seen for alcohol has not been so prominent. An advantage of a combined approach is that it poses the question why what applies to alcohol does not apply to drugs.

#### 2.1.4 *Increase in treatment system research*

The increased interest in treatment system research (Weisner, 1995; Weisner & Schmidt, forthcoming), is the result firstly of developments in scientific thinking, and secondly of the fiscal crises of health and welfare costs in even the wealthiest countries, which has brought a halt to the proliferation of treatment agencies.

The new epidemiology already mentioned is one of the contributors to the emerging tradition of treatment system research, with its findings on the conditions of treatment entry and more broadly on the social ecology of treatment. Another contribution is provided by studies of what really happens in referral and other relations between agencies C these often turn out to be studies of why referral does not happen very much C and of the careers of clients in the treatment system. A third contribution comes from studies of the conditions and patterns of growth and decline in treatment provision in particular jurisdictions or societies.

An emergent theme in this third group of studies, highly relevant to the present publication, is the growth of comparative studies of alcohol- and drug-treatment systems (Klingemann et al., 1992; Klingemann & Hunt, forthcoming). Until recently, it has been very difficult to find descriptions of national treatment systems in English; such descriptions as were available have been in the local language and were not regarded as having a broader audience. However, it is becoming clear that much might be learned from cross-cultural comparisons of treatment provisions and systems, and from a study of the history of such systems as well as their current patterns. Thus it appears that Sweden spends about six times as much on alcohol and drug treatment as the Canadian province of Ontario, though they have about the same population, size and similar profiles of alcohol and drug problems C and though the Ontario system is generally seen as well developed by North American standards. One big difference, it appears, is that in Sweden, as in Germany, the normative model of treatment has been an inpatient stay of 3-6 months C a model almost unknown among professional treatment milieux in North America.

### 2.2 **Harm-reduction approaches<sup>4</sup>**

In the context of illicit drug policies, a self-conscious harm-reduction approach was adopted within the last 10 years, particularly in England and Wales and Australia (Heather et al., 1993; Erickson et al., 1997). The initial primary emphasis was on the prevention of AIDS among intravenous drug users. The threat of the AIDS epidemic, it was argued, justified desperate measures, even if such action acknowledged and might appear to condone intravenous drug use. Prominent among these measures was making

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<sup>3</sup> Participants at the 1994 Advisory Group meeting at Harvard addressed harm-reduction approaches and drug and alcohol policies and laws. This section (2.2) is based on a paper presented by Dr Robin Room at this meeting (R. Room, unpublished observations, 1994b, as amended).

sterile syringes available to intravenous drug users, through needle exchanges and in other ways. This harm-reduction initiative motivated by the priority given to preventing AIDS was in line with some older approaches. Methadone maintenance, accepted since the 1970s in the United States but in countries like Germany only in the late 1980s, has also been commonly viewed as a harm-reduction approach, but what harm was being prevented and to whom has changed with time and place. While the main policy aim in the United States in the 1970s was to reduce the burden of crime on the community from illicit heroin users stealing to finance their supply, in Germany and elsewhere in the 1980s the provision of methadone has also been seen as a means of preventing HIV infection.

Another type of harm-reduction approach has been seen in the Netherlands, which has long adopted a policy of flexible policing and other policies whereby illicit drug use of limited kinds and in limited circumstances is tolerated with the aim of minimizing harm from such drug use. Over the years a coherent approach and ideology has emerged that is very much in the tradition of public health thinking. Thus public health agencies have long sought to limit the harm from sexuality, even if the particular sexual relations are illegal and the public health measures appear to condone the illegal behaviour. Venereal disease clinics, for example, are an old public health tradition, and have long fought off attacks on their existence as condoning immorality. The public health approach has long been clear, namely that it is appropriate to act vigorously to prevent immediate harm, even if the action taken may involve a potential risk of future harm.

In the specific context of illicit drugs, harm reduction also exemplifies a critique of the conventional approach to drug control in terms of a choice between supply reduction and demand reduction, the latter often being emphasized as an alternative to a focus solely on supply reduction. Supporters of harm reduction argue that both demand and supply reduction are focused solely on the *use* of the drug, and that attention should be refocused on the *harm* caused by such use. In a harm-reduction perspective, supply approaches and demand approaches are only a part of a broader spectrum of approaches to reducing drug-related harm.

This perspective is also in line with common ways of thinking about alcohol. When attention turned to the prevention of alcohol problems in the United States in the late 1960s and early 1970s, many argued explicitly for what was called a problem-minimization or harm-minimization approach to such problems (Room, 1974). This opened up a much broader range of options than the usual thinking at that time, which was in terms of publicity campaigns, education about the signs of alcoholism and efforts to improve the public image of the alcoholic. These options (Edwards et al., 1994) did include controls on alcohol availability, a neglected topic at the time, but also efforts to make the world both safer for drunks and safer from drunks: C seat belts and airbags in cars, "wet" hotels on skid rows, designated driver programmes, and so on. In societies where alcohol is a licit drug, there is usually agreement that measures to limit harm from drinking are a legitimate public health concern.

Harm-reduction approaches have also been common for tobacco smoking (Ferrence et al., forthcoming). These have included the provision of filters and reducing the tar content of cigarettes, although it has become apparent that smokers often unconsciously neutralize the harm reduction effects of these measures by changing their pattern of smoking. More recently, nicotine chewing gum and nicotine skin patches have exemplified a harm-reduction approach by providing a supply of the main psychoactive substance, nicotine, while eliminating damage to smokers' lungs and to others from breathing cigarette smoke.

Harm-reduction approaches have also steadily been gaining acceptance in international thinking about controlled drugs. The WHO Expert Committee on Drug Dependence at its twenty-eighth meeting (see section 1.4.11) (World Health Organization, 1993c), adopted a harm-reduction perspective, in line with public health traditions also reflected, for instance, the report on its twentieth meeting (World Health Organization, 1974). The Board of Directors of the International Council on Alcohol and Addictions, the premier international nongovernmental agency in the field, recently provisionally adopted a policy favouring a harm-reduction approach. It is clear that there is also a trend in this direction at national levels; Canada, for instance, has adopted a harm-reduction framework for its National Drug Strategy (Canada, 1992). However, the United States has taken the position internationally that "harm reduction" is an unacceptable term.

As harm reduction has become more widely accepted, there is beginning to be a more systematic probing of its premises and scope. Is the aim harm reduction or harm minimization, for instance? In an alcohol context, it is accepted that those who choose to drink often derive pleasure from it, and that limiting harm should not mean taking away that pleasure. The aim is thus some kind of balancing of the risks of harm against the pleasures, i.e. what might be called a harm-minimization approach, rather than an unrestrained effort to reduce the harm even if this took away the pleasure.

Then there is the issue of what is considered as harm (Fischer et al., 1997). The initial emphasis in harm-reduction approaches such as needle exchanges was on harm to the user C the risk of contracting AIDS C and perhaps also to others in close contact with the user, such as sexual partners. However, harm from drug use can affect others besides the drug user him- or herself, e.g. family members and friends, an industrial enterprise (through loss of productivity from a drug-using worker), the community faced with unsafe streets, etc.

It is commonly assumed that a focus on community-level harm will lead to a supply-reduction approach, while harm reduction is more focused on individual harms, but this is not necessarily the case. A major argument now current in the United States in favour of moving away from a focus on law enforcement to reduce the supply of drugs is that the violence associated with keeping a large market illicit imposes too great a burden of harm on the community. A similar argument about the need to

reduce lawlessness and its harm to society was influential in the repeal of the prohibition of the sale of alcohol in 1933 (Levine, 1985).

As has been noted (W. McAuliffe, personal communication, 1994), one effect of United States policy on the use of drugs has been that drug epidemiology, unlike alcohol epidemiology, has tended not to measure the actual harm experienced by drug users and those around them. At the individual level, the main harms from the use of psychoactive drugs seem to fall into four main categories: chronic health harm, casualties, psychological problems, and default of major social roles (Room, 1985). A focus on harm, and a wider framework like WHO's which includes alcohol, tobacco, and other substances outside international controls, will inevitably suggest a stronger emphasis on alcohol and tobacco. In any society where tobacco smoking is widespread and banalized, tobacco is likely to account for more deaths from chronic illness than any other substance. Where drinking alcoholic beverages is widespread and a part of daily life, alcohol will rival tobacco in terms of years of life lost from casualties and from chronic illness (Murray & Lopez, 1996). Tobacco is not usually involved in default of major social roles, but such default is at least as likely for the very heavy drinker as it is for the drug-user.

Harm-reduction approaches present some special challenges in documenting the international legal situation. Needle exchanges and marijuana bars (the Netherlands "coffee shops") often face a heavy weight of adverse international, national and often state or provincial law. Frequently, harm-reduction initiatives have been adopted at local level, and have involved activities that are illegal initially, needle exchanges often contravened state laws in the USA against distributing drug paraphernalia, for instance. Because of this lack of legal status, the proponents of such activities have instead often sought a *modus vivendi* with local authorities and the police, e.g. an informal agreement that the police will not obstruct or harass the effort. With a heavy load and long record of legislation at all levels of government in the drug area, there is some risk of ending up with apparently obsolete legislation which is often not applied in current real-life circumstances. Such legislation can sometimes be enforced in a different era, as has been seen with United States temperance-era dramshop laws in the 1970s and 1980s (Mosher, 1979; Solomon & Payne, 1996), but in cataloguing such laws it will be important to establish how often they are used and in what circumstances.

## **2.3 Changing policies**

We asked key contacts to describe proposed policy changes relating to treatment and rehabilitation for drug- and alcohol-dependent persons. No attempt is made to provide comprehensive coverage of all such changes. Some are shown briefly in Table 1 and/or are dealt with in greater detail in the text. Where available, current government policy objectives on treatment and rehabilitation as found in official published government strategy documents are reviewed in Chapter 7.



Table 1

Subjects of policy changes noted in unpublished survey responses (personal communications) relating to treatment and rehabilitation of drug- and alcohol-dependent persons<sup>5</sup>

Policy change	Country or territory
<ul style="list-style-type: none"> <li>• Government reorganization</li> <li>• Reform of existing policies</li> <li>• Decriminalization of "personal dose" of illicit drugs</li> <li>• Legislative change (recent or planned)</li> </ul>	Bolivia; Macao China Colombia; Italy Brazil; Israel; Macao; Morocco; Poland; Russian Federation; Senegal; Spain; Sri Lanka; Zimbabwe
<ul style="list-style-type: none"> <li>• Study commission or special committee established</li> <li>• Effective practical application sought</li> <li>• Trade: (a) certification for professional standards; (b) more legal pharmaceuticals coming into country means more abuse</li> </ul>	France; Sweden Madagascar; Thailand (a) Mexico; (b) Zimbabwe
<ul style="list-style-type: none"> <li>• Diversification of after-care services</li> <li>• Promulgation of administrative regulations on functions and internal organization of specialized units</li> </ul>	Poland Portugal
<ul style="list-style-type: none"> <li>• Reforms at the subnational level</li> <li>• Health insurance legislation for entire population including inpatient and outpatient detoxification, ambulatory treatment, drug maintenance centres</li> </ul>	Bolivia Israel
<ul style="list-style-type: none"> <li>• Harm minimization as a transforming idea, e.g. permitting needle exchange and methadone maintenance</li> </ul>	Austria; Australia
<ul style="list-style-type: none"> <li>• Deinstitutionalisation of mental patients under new law</li> <li>• Confirmation of importance of law enforcement and supply control</li> </ul>	Brazil Costa Rica
<ul style="list-style-type: none"> <li>• Informal reforms among clinicians, policy-makers, interest groups</li> </ul>	Ireland
<ul style="list-style-type: none"> <li>• Emphasis on "heavy" alcohol drinkers</li> <li>• Creation or improvement of facilities, personnel, approval procedures</li> </ul>	Kazakhstan Morocco; United Arab Emirates
<ul style="list-style-type: none"> <li>• Ratification of international drug conventions</li> <li>• Establishment of funds to finance treatment</li> <li>• Patients have right to choose clinics and physicians</li> <li>• Consideration of inclusion of substance-abuse services in private and public "managed care"<sup>6</sup> services</li> </ul>	Poland Egypt; Poland Latvia United States of America

<sup>5</sup> Tabulation is illustrative only and not intended to be comprehensive or inclusive of all policy changes in survey countries.

<sup>6</sup> Managed care plans have the following common characteristics: (i) they make arrangements with selected practitioners to furnish a specific set of health care services to enrollees; (ii) they have explicit criteria and standards for the selection of practitioners; (iii) they have formal programmes for ongoing quality assurance, quality improvement, and utilization review; (iv) they have financial incentives for members to use the practitioners and procedures that are covered by the plan. Source: Managing Managed Care, Quality Improvement in Behavioral Health, Institute of Medicine, National Academy Press, Washington DC, 1997, citing *Source Book of Health Insurance Data*, 1995, Washington DC, Health Insurance Association of America, 1996.

Table 1 (*continued*)

Policy change	Country or territory
• Controlled availability of heroin; costs-and-benefits trials proposed	Australia; Switzerland
• Use of religious centres as focus of rehabilitation activities of nongovernmental organizations	Bahrain
• Trend towards development of private services	Ecuador; Finland
• Local definite clinical-level policies need to be backed up by definite policy statements at national level	Ireland
• Political, economic, social changes cause uncertainty as to exact developments	China (Hong Kong); Slovakia
• Establishment of therapeutic centres	Thailand
• Development of national policy plan	Brazil; Senegal
• Public demand for change, including non-discrimination	India; Netherlands
• Based on move to harm minimization, facilities established which do not emphasize abstinence	Austria
• Legalization of certain drugs	
Welfare for alcohol- and drug-dependent persons, a local social welfare responsibility	Australia; Austria; United Kingdom Finland

In China (Federal), it is reported (S. Yucan, personal communication, 1993) that drafting of a new Mental Health Act was initiated in 1986, through professional meetings and symposia, and with the involvement of foreign experts, who provided information on mental health legislation in other countries. The draft has been revised nine times; since 1992, this activity, originally undertaken by the Ministry of Public Health, involves a number of different Government ministries and departments. It is also reported that alcohol dependence was not a significant problem in China until 1980. Since then, and attributed to the improvement in living conditions, the prevalence of alcohol dependence has risen, as shown by the results of a national survey carried out in 10 cities and among four categories of professionals, and headed by the WHO Mental Health Collaborating Centre. Medical alcohol problems are treated in general hospitals or psychiatric wards, as is drug dependence. In recent years problems of illegal trafficking in heroin and heroin abuse have reappeared in China, and special treatment centres for drug dependence have been established in many provinces under the Department of Drug Affairs of the Ministry of Public Health.

On 1 July 1997, in China, Hong Kong became a Special Administrative Region of China pursuant to a 1984 bilateral agreement with China. Also on 1 July 1997, the Basic Law of the Hong Kong Special Administrative Region of the People's Republic of China, adopted in April 1990, came into effect. This prescribes the systems to be practised in the Hong Kong Special Administrative Region in order to ensure the implementation of the basic policies of China regarding Hong Kong.

One of the general principles (Chapter I: General Principles, Article 8) of the Basic Law states that:

The laws previously in force in Hong Kong, that is common law, rules of equity, ordinances, subordinate legislation and customary law, shall be maintained, except for any that contravene this Law, and subject to any amendment by the legislature of the Hong Kong Special Administrative Region.

However, apart from the Decision of the Standing Committee of the National People's Congress on Drug Ban of 28 December 1990 (see section A2.2) there are no known provisions specifically on the treatment or rehabilitation of drug-dependent persons in China. Consequently, after 1 July 1997, it will now be necessary to reconcile treatment programme practice under the current Hong Kong drug-treatment legislation and the drug-control legislation of China. In 1999, the Hong Kong Special Administrative Region undertook several initiatives concerning treatment and rehabilitation. The Action Committee Against Narcotics (ACAN) commissioned two research studies: (1) on chronic drug abusers, particularly methadone patients; and (2) a study on the motivation strategy for engaging drug abusers for treatment, to assess current methods of persuading drug abusers, especially early drug abusers, to seek treatment (Hong Kong, 1999a).

In Finland, projects for the revision of policies, legislation and programmes were reported (J. Eskola, personal communication, 1993). There is a trend towards making use of private services as a means of expanding the rehabilitation services for alcoholics and drug-dependent persons, and related social benefits, and the development of welfare services for alcohol- and drug-dependent persons as part of the joint local population responsibility for social welfare and health care.

In Colombia, among the activities of the Presidential Programme on Drug Consumption ("RUMBOS") established pursuant to Decree No. 2193 of 26 October 1998, is designing government policies for prevention and treatment of drug consumption in Colombia (Colombia, 1999).

In Finland, the 1997 report by the Finnish Drug Policy Committee, *Drug Strategy 1997* (Finland, 1997) sets out an 18-point plan of action for years 1997-2001; including recognition that the Child Welfare Act provisions to involuntarily detain young persons for treatment should be used to a greater extent, after more study of the use of involuntary treatment. Moreover, the *Public Health Report*, issued in 1999 by the Ministry of Public Health and Social Affairs (Finland, 1999) informs the Finnish Parliament on developments in intoxicant abuse, and reports that concomitant abuse of different psycho pharmaceutical substances has increased; and that the most commonly used drugs in Finland are cannabis and amphetamines (Finland, 1999).

In France, Circular DHS/DH No. 96/239 of 3 April 1996 on policies with regard to the assumption of care of drug-dependent persons in 1996, indicates the

policies and areas requiring priority attention arising from the plan for control of drugs and drug dependence, announced by the government on 14 September 1995, including improving the care of drug dependent patients in hospitals, and better coordination between organizations in the health field, and for drug dependent persons in prisons.

In Germany, among the initiatives of the Federal Government Administration in 1998 was transfer of the Office of Drug Commissioner from the Ministry of the Interior to the Ministry of Health (Germany, 1998) with an emphasis on health and social aspects. In order to expand assistance to drug-dependent persons, two new approaches were established: (1) operation of injecting rooms "to be placed on a legal basis" (Germany, 1998); and (2) a pilot project for heroin-maintained treatment of opioid dependents who could not be reached by traditional assistance programmes (Germany, 1998). Also the 1998 report recognized the value of self-help groups, such as the Good Templars and Alcoholics Anonymous, in the treatment and follow-up of alcohol-dependent persons (Germany, 1998).

In Hungary it is reported (K. Szomor, personal communication, 1999) that a National Drug Coordination Committee was established in April 1998, replacing the Inter-Ministerial Committee of 1991. The Chairman of the Coordination Committee is the Minister of Youth and Sports, the co-chairman is the Minister of Health. Moreover, the Penal Code of 1978 has been modified, the last major series of amendment entered into force in March 1999.

In India, a need for reform has been identified. In 1993, the Law Commission of India (the constitutional body responsible for reforming the legal system) decided that a review of the Narcotic Drugs and Psychotropic Substances Act, 1985 was necessary.

In Ireland, it is reported (M. Lyons, personal communication, 1994) that treatment programmes have been reformed over the past 20 years informally, based on discussions among clinicians, policy-makers and interest groups, but that local policies on rehabilitation need to be supported by formal policy statements from the Department of Health.

In the Netherlands, the Government investigated the feasibility of the compulsory treatment of so-called "extreme problematic drug users", and of compulsory treatment in prison settings (P. Spruit, personal communication, 1994). As reported in 1999 (Netherlands, 1999a), criminal law provisions enable drug addicts who are repeatedly arrested to choose either to serve their entire sentence, or, enter treatment, by suspension of prison confinement, if they complete the treatment programme. Also, as reported in 1999 (Netherlands, 1999b), an example of this approach is the "Integrated Approach of Addiction-Related Problems and Nuisances". This is a three year pilot experimental programme, in Utrecht, intended to reduce crime and nuisance caused by drug-dependent persons who have committed five or more offences in the year prior to project participation. After court approved suspension of

confinement, some drug-dependent persons may choose between care or further confinement. A care manager prepares an "individual care extension course itinerary"; if a participant violates conditions, an independent judge may revoke the suspension and reinstate the provisional confinement. The treatment programme typically involves the goal of improving both physical and social functioning and motivation of addicts to continue or complete treatment. Aftercare treatment or assistance on a voluntary basis follows, including work training and supervised housing, with social integration a goal, it is reported (Netherlands, 1999a).

In Norway, The Norwegian Directorate for the Prevention of Alcohol and Drug Problems and The National Institute for Alcohol and Drug Research report (Norway, 1998) significant changes in drug treatment policies, legislation, and practices in the treatment sector, for example, in long-standing policy opposition to methadone maintenance. In 1989 a limited programme of methadone maintenance was initiated for HIV positive drug users with advanced immune system failure. Moreover, in 1992, the Ministry of Health in Norway initiated a three-year trial programme for 50 persons. In 1997 the Norwegian Parliament enacted a resolution making methadone available to all persons meeting established treatment criteria. Consequently, "from being an unavailable alternative for treatment of heroin addiction in the 1980's methadone treatment has now become an integral part of the treatment services offered to drug users", it is reported (Norway, 1998).

In Poland, which is a party to both the 1961 Single Convention (as amended in 1972) and the Convention on Psychotropic Substances, it was reported (J. Morawski, personal communication, 1994) that steps were being taken to ratify the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

In South Africa, the Department of Welfare stated in its *White Paper For Social Welfare* of August 1997 (South Africa, 1997) that "the approach to substance abuse should be comprehensive and intersectoral ... community-based treatment will be promoted ... for example day-care centres, outpatient services, mobile clinics and transit houses. Social services should be also available, not only for persons abusing substances, but also to the family, especially children".

In Sweden, it is reported (Sweden, 1998b) that "drug abuse care in Sweden has changed a great deal over the past ten years. Resources have been restructured from institutional to outpatient care".

It is reported (Switzerland, 1996) that the Tribunal des Mineurs (Juvenile Court) project in Bern, Switzerland was established with the goal of preventing the start-up of excessive drug use and crime. In the project the trial court involves a range of comprehensive community services to assist young offenders and emphasizes a non-stigmatizing approach to care for both the youth offender and their families. Multi-disciplinary teams are involved for strategic interventions designed to provide guidance and support.

The Juvenile Court approach has three objectives, as reported (Switzerland 1996): "consider the offence within an overall context, thus finding new ways to understand it; to develop secondary prevention within the context of the juvenile courts; and to work with families of offenders to find various solutions to their difficulties".

In the United Arab Emirates, it is proposed (El Zein Abbas, personal communication, 1994): (1) to increase the number of drug-treatment centres; (2) to change the existing legislation on capital punishment for drug traffickers; (3) to encourage public awareness programmes; (4) to establish nongovernmental organizations; (5) to establish a rehabilitation centre; and (6) to revise existing laws so as to provide for new centres. The National Committee for Drug and Alcohol Abuse Control recommended a collaborative approach to substance abuse, incorporating medical, legal, social and religious components. The Committee is headed by the undersecretaries of all the ministries. Recommendations are approved by the Supreme Council of the Emirates Rulers, and enacted as federal legislation.

In the United Kingdom, the government (United Kingdom, 1999) established performance targets to reduce drug misuse. One target is increasing the participation of "problem drug misusers", including prisoners in drug treatment programmes 100 per cent by 2000 and 66 per cent by 2005.

In the United States, it is reported (United States, 1997c) that pursuant to the Federal Government's Crime Act initiatives, over 150 communities have reviewed some US\$33 million in federal funds to plan, implement or improve drug courts and that "50 to 65 per cent of drug court graduates stop using drugs". The key components of drug courts include: (1) drug courts integrate alcohol and other drug treatment services with justice system case processing; (2) eligible participants are identified early and promptly placed in the drug court programme; (3) using a non-adversarial approach, prosecution and defence counsel promote public safety while protecting participants' due process rights; and (4) drug courts provide access to a continuance of alcohol, drug and other related treatment and rehabilitation services (United States, 1997c).

## **2.4 National legislative activities**

An important indicator of the status and effectiveness of legislation on the treatment of drug- and alcohol-dependent persons in any country is the interest in fundamental change in the field (Porter, Arif & Curran, 1986).

During the period since the 1982-1983 survey, which provided the basis for the 1986 WHO publication, legislative activity has occurred in many countries in response to both national initiatives and technological changes. Significant new legislation establishing national coordinating commissions, or advisory bodies, with

duties involving treatment and rehabilitation has been enacted in: Algeria, Belize, Canada, Cape Verde, Costa Rica, Côte d'Ivoire, Dominica, Ecuador, Finland, France, Ghana, Greece, Israel, Italy, Papua New Guinea, Saint Lucia, Senegal, South Africa, Spain, Syrian Arab Republic, Togo, Tunisia, United States of America and Venezuela.

In addition, new legislation providing for the compulsory commitment of drug- or alcohol-dependent persons has been adopted in countries or territories in each of the six WHO Regions: *Africa* (Kenya, South Africa); *Americas* (Bolivia, Colombia, Ecuador, Mexico, Venezuela); *Eastern Mediterranean* (Kuwait, Pakistan, Tunisia); *Europe* (Czech Republic, Denmark, Finland, Greece, Hungary, Italy, Kazakhstan, Latvia, Norway, Poland, Russian Federation, Spain (Catalonia), Sweden, Switzerland, Ukraine); *South-East Asia* (Bangladesh, India, Myanmar, Thailand); and *Western Pacific* (China [Hong Kong, Macao], Japan, Malaysia, Tonga, Viet Nam).

Significant new legislation providing for treatment associated with the criminal justice system was enacted in several countries in the survey. Legislatures in several countries enacted provisions for diversion to treatment and assistance for persons found to be in possession of illicit drugs, but in amounts limited to what is variously defined in the legislation as "dose for personal use" or "daily average requirement for personal use alone", or "minimum quantities". For example, a "dose for personal use" is defined in Colombian legislation (Law 30 of 1986 (31 January) Adopting the National Narcotic Drugs Statute and enacting other provisions) to mean an amount of a narcotic drug that a person carries or keeps for his own consumption. The dose for personal use may not exceed twenty (20) grams of marihuana, five (5) grams of marihuana hashish, one (1) gram of cocaine or any cocaine-based substance and two (2) grams of methaqualone. Any narcotic drug carried by a person for the purpose of distribution or sale may not be regarded as a dose for personal use, regardless of the quantity. The countries in our survey having legislation containing a "personal dose" or equivalent provision include Bolivia, Chile, Colombia, Costa Rica, Italy, San Marino and Venezuela. Use of quantities greater than the personal dose make the user liable to the full weight of fines, imprisonment, and other penalties imposed by legislation of this type for the control of dangerous drugs. In Hungary, it is reported (K. Szomor, personal communication, 1999) that a 1999 amendment of the drugs related measures of the Penal Code of 1978 defines the exact quantities for the "small" and "significant" quantities of illegal drugs.

We summarize below important legislative developments in each of the six regions of WHO.

#### 2.4.1 *African Region*

In Kenya, the Mental Health Act, 1989 (repealing the earlier Mental Treatment Act) provides for compulsory civil admission for persons suffering from a mental disorder, who are likely to benefit from treatment in a mental hospital, including those

suffering from mental impairment due to alcohol- or substance-abuse. Substance abuse is defined in the Act as a maladaptive pattern of use as indicated by either recurrent or continued use of any psychoactive substances. These are enumerated in the Act, and include alcohol, amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, sedatives, hypnotics, and anxiolytics, where their use causes or exacerbates persistent or recurrent social, occupational, psychological or physical problems. In Madagascar, it is reported (C. Ralambo, personal communication, 1994) that Decree No. 92-1044 of 22 December 1992 (amended by Decree No. 94-357 of 31 May 1994) established the Interministerial Coordinating Body for Drug Abuse Control, a body responsible for defining, promoting and coordinating national policy aimed at controlling drug abuse and illicit trafficking in narcotics and psychotropic substances. In Senegal, it is reported (M.L. Fofana, personal communication, 1994) by the Ministry of Justice that a code on the use of drugs is being developed. This has two objectives: (1) the harmonization of the legislation of French-speaking countries in Africa; and (2) uniform provision for both the lawful and unlawful use of dependence-producing drugs. In South Africa, the Prevention and Treatment of Drug Dependency Act, 1992, was enacted; it repealed numerous provisions in effect prior to constitutional reform. In South Africa, the 1999 Prevention and Treatment of Drug Dependency Amendment Bill, 1999 was introduced to establish a Central Drug Authority with power to draft a National Drug Master Plan, setting out the policy and strategies against the abuse of drugs as adopted by the Cabinet.

#### *2.4.2 Region of the Americas*

There have been significant proposals for the reform of provincial legislation in Canada. In the province of Nova Scotia, it is reported that the Narcotic Drugs Act of 1997 is considered outdated by the Ministry of Health, as not in keeping with contemporary philosophies and approaches to treatment. The Heroin Treatment Act, 1979, of British Columbia is reportedly in the process of being significantly changed. Three countries in South America (Bolivia, Colombia, Ecuador) have enacted drug-control legislation containing provisions for the compulsory commitment or other matters concerning treatment of drug-dependent persons.

In Colombia, Decree No. 2193 of 26 October 1998 created the Presidential Programme on Drug Consumption ("RUMBOS") designed specifically to address consumption of psychoactive substances by Colombians (Colombia, 1999).

In Mexico, the General Health Law of 1984 replaced the Sanitary Code of 1973. The Regulations of 7 January 1981 for the control of substances which are psychotropic when inhaled require the Secretariat of Health and Welfare to provide medical care and social assistance to persons suffering from the consequences of inhaling such substances. Appropriate health, educational and rehabilitative measures are to be taken in cases of habitual or repeated inhalation of such substances.



In the United States of America, significant national legislation, namely the Anti-Drug Abuse Act of 1988, has been enacted. It requires the Federal Government to produce annually (which have been produced since 1989) a comprehensive National Drug Strategy, including measurable goals and the resources needed to attain them. Supply-control measures are supplemented by a demand-reduction strategy of support for treatment and prevention programmes through grants in aid; a programme of extramural and intramural research on drug abuse; and enforcement and promotion of so-called "user accountability" measures, designed to discourage drug use by imposing civil and criminal sanctions on drug users (United States of America, 1994). Also, drug court programmes in several cities of the United States of America showed that court-ordered rehabilitation programmes can be successful in reducing drug use while easing over-crowding in prisons and jails. In drug courts, qualifying drug-using offenders are placed in court-ordered rehabilitation programmes requiring drug testing and intensive supervision and treatment. If an offender fails to meet court-ordered requirements, graduated sanctions, including increased supervision, residential treatment, community-based incarceration, and jail or prison sentences, are used to pressure the offender to become drug free (United States, 1994). It is reported by the United States (United States, 1998a) that in 1997 approximately 20 000 defendants appeared before the nation's 215 drug courts, and that 160 were in 1997 in the planning stages. Also, several jurisdictions were considering how adult courts could be adapted to deal with substance abusing juvenile offenders. On average, over 70 per cent of adult drug court participants stay in treatment, it is reported (United States, 1998a).

In Venezuela, the general objective of Resolution No. G-1112 of 16 June 1988 is to offer the therapeutic options necessary for the patient's improvement and reintegration into the family and social environment. Approved establishments must provide integrated care to all persons who come to such establishments requesting clinical care in order to overcome the problem of drug dependence; provide guidance, care, and treatment to families who come to such establishments because one of their members is a drug user; carry out research activities in the field of drug dependence; and evaluate the effectiveness of their programme.

### 2.4.3 *European Region*

In Austria (Austria, 1998) the Narcotic Substances Act entered into force on 1 January 1998: (1) replacing the provisions of the Narcotic Drugs Act of 1951, as amended; (2) continued the principle of "therapy instead of punishment"; and (3) provided for alternatives to prosecution for drug addicted persons - suspension of prison sentences for committed drug addicted persons, up to three years is provided in the Act in order to provide treatment of the offender. Also, the Narcotic Substances Act of 1998 provides for a range of health-related measures for those in treatment, such as clinical psychological counselling and care, psychotherapy, and substitution treatment. Methadone is the preferred substitution, however, other substances may be

used, such as sustained release morphine for drug addicted patients, living with HIV infection.

In the Czech Republic, the Law of 28 March 1989 on the Protection Against Alcoholism and other Drugs is reported to be much less vigorously applied than it was under the previous political administration. Revision of this law is being considered by the Ministry of Health. In Cyprus, it is reported (V. Pyrgos, personal communication, 1994) that a new law of 1992 provides for the treatment of drug offenders.

In Denmark, Order No. 603 of 1 July 1992 (pursuant to Law No. 349 of 14 May 1992 on the detention of drug-dependent persons undergoing treatment) contains provisions governing the protection of drug-dependent patients' rights; the enforcement and maintenance of detention; the conditions governing physical constraint and isolation; and the content of a report to be prepared when a person is placed in detention. In France, Decree No. 98-1229 of 29 December 1998 on the centres referred to in Article L.355-1-1 of the Public Health Code, requires that outpatient centres for the treatment of alcohol dependence must provide diagnosis, guidance and therapeutic management as well as social support to persons and their families, and that centre staff must consist of multi-disciplinary medico-social teams, operating under a treatment plan. In Hungary, it is reported (K. Szomor, personal communication, 1994) that the Criminal Code was amended on 15 May 1993 by the addition of Section 282, providing that a person can be imprisoned for violating official regulations. Under Section 282A, a person cannot be punished who cultivates, produces, purchases or keeps a small quantity of narcotic drugs for personal usage; or commits an offence punishable by less than two years' deprivation of liberty connected with the consumption of narcotic drugs, provided that, before the sentence of the court of first instance, he certifies that he has participated in a continuous course of treatment of at least six months' duration aimed at preventing or "curing" narcotic drug dependence. A 1999 amendment to Hungary's Penal Code defines the exact quantities for the "small" and "significant" quantities, it is reported (K. Szomor, personal communication, 1999). In Hungary it is further reported (K. Szomor, personal communication, 1999) that the amendment of 1993 was changed in 1999, as follows: penal measures for illegal production, storing, trafficking, trading of narcotic drugs and psychotropic substances became more serious. For example, drug consumption is reintroduced as a violation of the Penal Code; the exact quantities for the "small" and "significant" quantities of illegal drugs are defined; and alternatives for illicit drug users subject to criminal procedures are: treatment, fine and public works. Also in Hungary, (K. Szomor, personal communication, 1999) Law XXV of 1998 on the medicines used for human purposes was enacted, including special measures regarding the production, trafficking, wholesale trade and pharmaceutical trade, storage, the medical prescription and use of narcotic drugs and psychotropic substances. In Ireland, one of the key priorities of the Government's Action Programme For the Millennium (Ireland, 1999) is creating a Drug Court System which would involve court-supervised treatment programmes as an alternative to criminal prosecution for less serious drug-related offences (European Union, 1998); as discussed in the Second Report of the

Ministerial on Measures to Reduce the Demand for Drugs (Ireland, 1997). Also, a review of the Alcoholism and Drug Addiction Act 1966 is being conducted, as directed by the 1998 National Drug Policy. The Alcoholism and Drug Addiction Act 1966 provides for the compulsory detention and treatment of alcoholics and drug addicts at certified institutions and is administered by the Ministry of Health. See Chapter 11 for a more detailed discussion. In Israel, the Institutions for Drug Users (Supervision and Treatment) Law, 5723-1993, which includes the licensing requirements for institutions for the social and medical care of drug-dependent persons, was passed by the Knesset on 6 July 1993. Section 35 of the National Health Ordinance, 1940, was replaced by a new section providing for the registration, organization and operation of institutions for drug users. In Kazakhstan, it is reported (B. Ajdeldjaev, personal communication, 1994) that legislation and government policy on drug dependence is based on the regulations of the Ministry of Health of the former Soviet Union, but that programmes are being developed based on current national, cultural and social conditions in the country. In Latvia in 1990 the Board of Health Protection Ministers issued Decision No.7 on Strengthening the Medical and Social Support for Patients Dependent on Alcohol, Drugs and Toxic Substances, which applies to inpatient and outpatient care, rehabilitation and social care. Moreover, draft legislation containing provisions for the rehabilitation of drug-dependent persons was in preparation, applicable primarily to homeless or unemployed persons. In Lithuania, it is reported (V. Struoga, personal communication, 1993) that treatment and rehabilitation is provided in "the old legislation functions", e.g., the decrees of the Supreme Soviet of the former Lithuanian Soviet Socialist Republic providing that persons who voluntarily apply for medical assistance related to drug dependence may avoid punishment under the criminal law. On 8 January 1998, Lithuania enacted No. VIII-602, the Law on The Control of Narcotic and Psychotropic Substances for the Classification of Narcotic and Psychotropic Substances for lawful circulation of those substances when they are used for health care, veterinary and scientific purposes, in accordance with international agreements. In the Netherlands, (Netherlands, 1999a) Article 47 of the Penitentiary Enactment permits drug addicts to substitute their imprisonment by clinical treatment in the last term of their sentence.

Significant policy and legislative reforms have been introduced in the Russian Federation in relation to both drug and alcohol abuse. Drug policy is set out in the Resolution of the Russian Federation on the principles of State policy in regard to narcotics control in the Russian Federation, dated 22 July 1993. The Resolution provides that State policy on narcotics control must provide a balanced set of measures to prevent and stop the illicit trade in narcotics and to reduce demand. It should be based on several main principles, including the improvement of the procedure for regulating the lawful distribution of narcotics; the control of illicit distribution; the prevention of the illicit use of narcotics; and treatment and social rehabilitation for drug addicts. On alcohol, the major recent legislation reported is the Decree of the Supreme Council of the Russian Federation, dated 21 June 1993, implementing the Law on Institutions and Organs Executing Criminal Punishments in the Form of Imprisonment. This Decree reportedly requires medical and labour preventoria to

cease operation by 1 June 1994. Pursuant to this Decree, persons who had been committed to such institutions under decrees of the former Soviet Union, were released. Legislation enacted by the USSR on alcohol abuse included: (a) the Decree of 25 August 1972 on the compulsory treatment and labour rehabilitation of drug-dependent persons who evade treatment or continue to take narcotics after initial treatment; (b) the Decree of 1 March 1974 on the compulsory treatment and occupational rehabilitation of chronic alcoholics; (c) the Decree of the Council of Ministers of the USSR on Measures on Overcoming Alcohol Abuse and Eradicating Bootlegging, dated 7 May 1985; and (d) the Order of the Presidium of the Supreme Council on Strengthening the Control Over Alcohol Abuse, dated 16 May 1985. The last two of these have remained in force.

The Russian Parliament is reportedly (V.E. Pelipas, personal communication, 1994) considering the enactment of draft laws on: (a) the social rehabilitation of alcohol and drug addicts; (b) the basic principles of anti-alcohol policy in the Russian Federation; and (c) State alcohol policy in the Russian Federation. The last of these was proposed by the Ministry of Internal Affairs and the Ministry of Justice. Physicians are also discussing another draft special law on "rendering narcological aid". In Spain (Castile and León) Law No. 3/1994 of 29 March 1994, on the prevention of drug dependence and the care and social reintegration of drug-dependent persons is significant because it is sub-national legislation stating details for care of drug dependent persons at primary, secondary and tertiary levels.

In Sweden, several laws have been enacted: the Social Services Act (SFS 1980: 620), with amendments up to and including SFS 1998:855; the Care of Abusers (Special Provisions) Act/LVM<sup>7</sup>/ (SFS 1988:870) Act, with amendments up to and including SFS 1997:1097; and the Care of Young Persons (Special Provisions) Act/LVU<sup>8</sup> (SFS 1990:52), with amendments up to and including SFS 1996:1648. On 8 October 1998, the Swiss Parliament enacted legislation authorizing the prescription of narcotics for a limited number of severely addicted drug users meeting the following criteria: (1) heroin addiction for a minimum of two years; (2) over 18 years of age; (3) at least two relapses to drug use after failures in outpatient or inpatient treatment; and (4) obvious adverse effects of drug use on health and/or social relations (Switzerland, 1999a). The legislation enacted 8 October 1999 is in effect until 31 December 2004, based on passage of the measure in a 13 June 1999 national referendum. However, revision of the Swiss Federal Law on Narcotics is required; an expert commission of the Swiss Department of Home Affairs published its report with recommendations for future legislation (Switzerland, 1999b); and the Swiss Federal

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<sup>7</sup> The initials (LVM) refer to the abbreviation used for the name of the (SFS 1988:870) Act in Swedish: Lag om vård av missbrukare, i vissa fall (Act on the Treatment of Alcoholics and Drug Misusers).

<sup>8</sup> The initials (LVU) refer to the abbreviation used for the name of the Act in Swedish: Lag om vård av unga. (The Care of Young Persons (Special Provisions) Act).

Government was expected to submit a draft revised law to the Parliament in 2000. In the Ukraine, two items of legislation have recently come into force. Of these, the first are the Principles of the Legislation of Ukraine on Health Protection, which came into force under the terms of a Resolution of the Supreme Soviet of Ukraine, dated 19 November 1992. The second, the Decree of the Supreme Soviet of Ukraine, dated 17 August 1966, as amended, provides for the compulsory treatment of chronic alcoholics. In the United Kingdom (England and Wales), the Crime and Disorder Act 1998 authorizes courts to make a drug treatment and testing order for offenders aged 16 or over who "are dependent on or has a propensity to misuse drugs", for treatment of not less than six months, nor more than three years. Such drug treatment and testing orders are considered as "fast tracking treatment", tailored to persons convicted of "acquisitive crimes" to fund their drug dependency (United Kingdom, 1997) (United Kingdom, 1998b).

#### **2.4.4 *Eastern Mediterranean Region***

In Iraq, it is reported (I. Al-Adhmawi, personal communication, 1993) that the Psychotropic Act 1991 is unpublished and consists of eight parts. The Mental Health Act 1991 is unpublished and includes provisions for the care of persons dependent on both alcohol and drugs, e.g. compulsory admission to hospital or guardianship, care for accused or convicted mentally ill patients in special wards, and informal admission to hospital.

In Morocco, it is reported (M. Paes, personal communication, 1993) that Morocco signed the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, in 1988 and ratified it in 1993. Legislation is currently being developed to conform to the 1993 ratification requirements. In addition, legislation is going to be developed that will be compatible with treatment and rehabilitation programmes. In Pakistan, there are no specific legislative provisions pertaining to treatment and rehabilitation, although a draft mental health law is under active consideration. It is proposed to establish adequately equipped detoxification centres at the Federal and district headquarters hospitals, to provide specialized treatment services for drug dependent persons, particularly those using heroin. It is reported (M.H. Mubbashar, personal communication, 1994) that a long-term goal of Pakistan government policy is the drafting of a comprehensive law that would bring national law into line with the international conventions. In the Syrian Arab Republic, Law No. 2 of 12 April 1993 repeals Law No. 182 of 1960 and incorporates provisions for the control of narcotics and psychotropic substances. Under Section 71, the Ministry of Public Health must establish facilities for the treatment of persons dependent on narcotics, and may also establish facilities for those dependent on psychotropic substances. In Tunisia, Law No. 95-94 of 9 November 1995 amending Law No. 92-52 of 18 May 1992 on Narcotics, authorizes courts to order one of several actions for children: detoxification; psycho-medical treatment; or measures under the Child

Protection Code (Law No. 95-92 of 9 November 1995) such as placement in guardianship.

#### 2.4.5 *South-East Asia Region*

In Bangladesh, the Narcotic Drugs and Psychotropic Substances Control Act, 1990, provides for the compulsory civil commitment of any person who "often remains in a state of abnormalcy for being addicted to narcotics and his treatment is urgently necessary to bring him back to normal life".<sup>9</sup> The Act provides also that no person shall possess or use any alcohol, and that no person may drink alcohol without a permit issued under this Act. Alcohol is defined in the Act as spirits and any kind of liquor or wine, and includes any liquid containing more than 5% of alcohol. It is reported (C. Rabbani, personal communication, 1994) that a Mental Health Act has been drafted and put before the Ministry of Health and Family Welfare, for subsequent review by the Ministry of Law and by Parliament, and enactment. Drug abuse and alcohol dependence are regarded as a form of mental illness, and the draft act provides for treatment. In India, the Narcotic Drugs and Psychotropic Substances (Amendment) Act, 1988 (Act No. 2 of 1989), amended the Narcotic Drugs and Psychotropic Substances Act, 1985, and provides immunity from prosecution to addicts volunteering for treatment. The Mental Health Act, 1987, provides that both the central government and the state governments may establish or maintain psychiatric hospitals or psychiatric nursing homes for the admission, treatment and care of mentally ill persons. Separate psychiatric hospitals and psychiatric nursing homes may be established or maintained for those persons who are addicted to alcohol or to other drugs which lead to behavioural changes.

It is reported (H.A. Nawawi, personal communication, 1994) by the Ministry of Health of Indonesia that Law No. 9 of 1976 on narcotics is under revision. In Myanmar, the Narcotic Drugs and Psychotropic Substances Law, enacted in 1993, repeals the Narcotics and Dangerous Drugs Law, 1974. The 1993 law requires drug-users to register at places prescribed by the Ministry of Health or at a medical centre recognized by the Government for medical treatment; failure to do so is punishable by imprisonment for a period of between three and five years. In 1991, the Rehabilitation of Narcotic Addicts Act B.E. 2534, was enacted in Thailand.

#### 2.4.6 *Western Pacific Region*

There is no separate legislation in China providing for the compulsory civil commitment of drug- or alcohol-dependent persons. However, several significant measures for the control of narcotic and psychotropic drugs were recently enacted, as follows: (1) Resolution of the Standing Committee of the National People's Congress

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<sup>9</sup> Unofficial English translation (official text in Bangla).

Concerning Prohibition Against Narcotic Drugs, 1990; (2) Measures for the Implementation of the Pharmaceutical Administration Law of the People's Republic of China, 1989; (3) Measures for the Control of Narcotic Drugs, 1987; and (4) Measures for the Control of Psychotropic Drugs, 1988. The Constitution (Article 61) of the Socialist Republic of Viet Nam, adopted on 15 April 1992, prohibits the production, trafficking, storage, or illegal use of opium and other narcotics. The Constitution also requires the establishment of a mandatory system "for weaning addicts and for treating other dangerous social diseases".<sup>10</sup>

In the Hong Kong Special Administrative Region of China, the Correctional Services Department compulsory drug treatment programme is operated under the provisions of the Drug Addiction Treatment Centres Ordinance (Chapter 244) which provides for the detention for treatment of a drug dependent person who has been found guilty of an offence. The Drug Addicts Treatment and Rehabilitation Ordinance (Chapter 326) provides for treatment of any person who is an addict and should be receiving treatment for his addiction. In the Macao Special Administrative Region, China resumed sovereignty over Macao on 20 December 1999, from its prior status under Portuguese administration (Macao, 1999).

In Japan, for an excellent comprehensive analysis, covering developments since World War II, of legislation relating to control of narcotics and psychotropic substances, see *Report on Administrative Measures Against Narcotics and Stimulants Abuse* published by the Ministry of Health and Welfare, November 1998 (Japan, 1998).

In New Zealand, the 1998 New Zealand National Drug Policy directed, with a view to possible amendment, a review of the Alcoholism and Drug Addiction Act 1966 (which provides for the involuntary commitment of alcohol- and drug-dependent persons at certified institutions). The review addresses several issues, such as: (a) the inability to match treatment types to client needs; (b) a lack of certified institutions; (c) institutions being unable or unwilling to accept clients; and (d) inconsistency with the New Zealand Bill of Rights Act 1990, and the compulsory assessment and treatment provisions of the Mental Health (Compulsory Assessment and Treatment Act) 1992 (New Zealand, 1998c).

## **2.5 Federal systems**

Federal governments have crafted in different ways policies- and legislation-enabling programmes. Action at the federal level is required, in part, because national governments are parties to the three international drug control conventions, including the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, and its provisions providing for treatment and rehabilitation. However, several of the countries in the current survey (e.g. Australia, Brazil, Canada,

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<sup>9</sup> English translation (*IDHL*, 1993, 44 (4)).

China, Germany, India, Mexico, Pakistan, Russian Federation, Switzerland, United States of America) have a federal or comparable system of government, so that both general and specialized health programmes are often planned, funded and delivered at the subnational (i.e. state, provincial, cantonal, or municipal) level. The role of subnational governments and local municipal authorities in the delivery of treatment and rehabilitation services for drug and alcohol dependence is therefore of great importance.

In the section which follows, activities of both national and subnational governments are discussed.

### **2.5.1 *Criminal law and illicit drugs***

Criminal law is usually the responsibility of the Federal Government (though it may be shared with the subnational governments) and focuses on the control of activities related to illicit drugs. Similarly, the regulation of controlled substances is usually the responsibility of the federal government. In contrast, legislation on alcohol dependence is usually enacted at the subnational level.

Attention in the Congress of the United States of America has been focused on law enforcement as a method of combatting drug-related criminal activity by: (1) increasing the penalties for drug-related crimes; (2) providing additional funding for drug-control initiatives; and (3) strengthening the coordination of Federal drug-control activities. Since 1984, Congress has enacted five Federal anti-crime laws containing drug-related provisions.

### **2.5.2 *Funding Substance-Abuse Services and Research*<sup>11</sup>**

The most well-intentioned policies and laws are of no real value unless effectively applied. Drug and alcohol treatment and rehabilitation services and research programmes therefore require adequate and sustained funding. Finding an acceptable balance in sharing the responsibility for such funding is a continuing source of tension in federal legislative systems.

In the United States of America, public funding for the treatment of substance abuse is the responsibility of both Federal and state (subnational) governments. Private funding is provided through health insurance programmes, and through foundations and other voluntary bodies. At the Federal level, a variety of departments and agencies

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<sup>10</sup> Participants at the 1994 Harvard Advisory Group meeting addressed the funding aspects of national and subnational treatment and rehabilitation programmes. This section (2.5.2) states the main elements of the paper presented at the meeting by Dr Mary A. Jansen, on the subject of funding, monitoring, and evaluation aspects of national and subnational treatment and rehabilitation programmes (M.A. Jansen, unpublished observations, 1994).



share the responsibility for funding, monitoring and evaluating public substance abuse treatment programmes. The Federal government departments (ministries) that provide funding include Health and Human Services; Justice; Education; Agriculture; Treasury; Transportation; Defense; State; and the Bureau of Alcohol, Tobacco and Firearms.

At the state (subnational) level, health departments, as well as state alcohol- and drug-abuse departments provide funds for treatment and rehabilitation programmes, sometimes using Federal funds provided to states through a Federal substance abuse prevention and treatment "block grant". Within the Federal Government, publicly funded substance abuse treatment is primarily the responsibility of the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the Public Health Service (PHS) in the Department of Health and Human Services. SAMHSA has the lead Federal responsibility for funding and evaluating treatment and rehabilitation programmes, under Public Law 102-321 (see e.g. Subpart II: Block grants for prevention and treatment of substance abuse). These activities are carried out through SAMHSA's Center for Substance Abuse Treatment (CSAT) - the national service demonstration grant programmes targeted to a specific purpose being the primary funding mechanism for CSAT action.<sup>12</sup> CSAT funds provide a wide range of treatment demonstration programmes each of which contains an evaluation component. These programmes include: a target cities programme; residential services for pregnant women and their infants; a special populations programme; a criminal justice programme; and a primary care linkage programme.<sup>13</sup> In addition to SAMHSA, the National Institutes of Health (NIH), including the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) provide funds for research grants. Many of NIDA's and NIAAA's efforts are designed to identify and test new approaches to treatment, including pharmacological treatments. These institutes also conduct research on the service delivery system to determine the best setting for various treatment services, and the cost-benefit ratios of various services. The Federal Bureau of Indian Affairs and the Indian Health Services also provide treatment services to tribal nations, which have special status and are considered to be separate entities, in particular for purposes of substance abuse treatment and rehabilitation.

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<sup>11</sup> CSAT grants made in 1990-1991 distributed approximately US\$240 million over three years to more than 430 treatment units, providing services to some 100,000 drug or alcohol dependent persons (United States, 1997b).

<sup>12</sup> See The National Treatment Improvement Evaluation Study (NTIES) for an evaluation of the impact of drug and alcohol treatment on 4,411 people who participated in programmes funded by CSAT (e.g. pregnant and at risk women; persons in the criminal justice system). Among the key findings of the NTIES study were: (1) clients served by CSAT-funded programmes significantly reduced their alcohol and other drug use; (2) treatment has lasting benefits, e.g. reductions in drug and alcohol use were noted regardless of the amount of time spent in treatment or the amount of treatment received; and (3) clients reported increases in employment and income, improvements in mental and physical health, decreases in criminal activity, decreases in homelessness, and decreases in behaviours that put them at risk for HIV/AIDS infection, one year after treatment (United States, 1997b).

### 2.5.3 Substance Abuse and AIDS: coordination of national and subnational action

It is important to take into account the diversity of substance abuse in relation to other public health problems (e.g. AIDS), to review policy, legislation and practice in federally structured countries, and to identify how such countries have created opportunities to develop effective partnerships in service delivery and funding patterns.

Throughout our international survey, therefore, we emphasize the importance of understanding how apparent conflicts in law between federal and subnational jurisdictions have been resolved in efforts to control drugs and provide treatment and related services. This is illustrated in the following examples of lawful sterile needle-exchange programmes in federal and comparable jurisdictions (Australia, Germany, Switzerland), where coordination of the roles of national and subnational authorities is essential in achieving public health goals.

Australia has a federal structure. Apart from the Federal Government, each of the six states and two territories has its own government. None of these jurisdictions has exclusive responsibility for health; each has the power to establish health policies and to enact health legislation. The Australian Federal Government's long-term goal concerning drug use in the community is to bring about a reduction in the number of drug-users. The primary aim of the Federal Government in such national efforts as the National Campaign Against Drug Abuse (Australia, 1990) is therefore to promote abstinence from drug use. However, the Government emphasizes in the National AIDS Strategy (Australia, 1989) that this goal (drug use abstinence) may only be achieved in the long-term and must be complemented by other strategies to reduce HIV transmission among intravenous drug-users. Australia's *National Drug Strategic Plan 1993-1997* (Australia, 1993a) is based on a harm reduction principle recognizing a wide range of approaches, including abstinence; comprehensiveness, to cover alcohol, drugs and tobacco; linking law enforcement and community groups. A 1998 ministerial council continues this integrated approach (Australia, 1998).

The Australian Federal Government's position is that the most effective strategy for preventing HIV infection among injecting drug-users is to reduce the number of drug-users, which, as already mentioned, is its long-term goal in addressing drug use in the community. In addition, however, the National AIDS Strategy calls for steps to be taken to minimize harm among existing drug-users, e.g. through the development of needle-exchange programmes. Under the National AIDS Strategy, the needle-exchange programmes are to: (1) operate in all states, in both urban and rural areas; (2) serve as safe disposal points for used equipment; (3) provide education about HIV transmission; (4) promote harm reduction through total abstinence from drugs; and (5) provide basic health services.

In Germany, both drug-control policy and AIDS-control policy are well developed, each playing a key role in determining the legal environment surrounding

the availability of sterile injecting equipment. Although cannabis/hashish use is considered to be the drug problem affecting the largest number of persons, opiate use is the most serious. More than 60,000 persons are estimated to be dependent on heroin, other opiates, prescription drugs, or cocaine. Injection is the most common method of taking drugs. The German national drug-abuse control plan, which was adopted by the Federal Government and the various *Länder* in December 1989, and subsequent plans, have established the general framework for German drug-control policy. Total abstinence from illegal drugs is the explicit aim of all prevention measures, in conjunction with treatment and comprehensive care for those who abuse drugs, including consultation, treatment, after-care, rehabilitation, and vocational and social services. One of the basic principles of German drug policy is that treatment is more effective than punishment.

In Switzerland, the Federal Law on Narcotic Drugs, dated 3 October 1951, as amended, gives the authorities discretion not to prosecute if treatment is provided and rehabilitation is to be expected. This law is binding on the cantons, which implement it, but changes cannot be made without their permission. An important aspect of Federal drug policy as enacted into law is that it prohibits the use of drugs, as well as possession and trafficking. Article 15a of the Federal Law on Narcotic Drugs provides that the prevention of drug abuse and the provision of care for drug-abusers is the responsibility of the cantons. The Federal authorities coordinate and promote local programmes on HIV infection among drug-users by providing financial support for pilot projects, and by conducting information campaigns. However, the Federal Law on Narcotic Drugs contains no specific provisions governing the supply of sterile needles and syringes which, under the Swiss federal system, is covered by cantonal law.

In the United States of America, the management of public health problems related to substance abuse, such as HIV infection associated with injecting drug use, as well as local crime "on the streets", is the responsibility of subnational jurisdictions, often in partnership with the Federal authorities. See Chapter 15 for a discussion of policy and legislative development at both federal and state level on needle exchange programmes.



### 3. WHO's Reports on treatment and rehabilitation

#### 3.1 Overview

This chapter presents the views on treatment and rehabilitation from a public health and medical perspective, as reported by the WHO Expert Committee on Drug Dependence and other WHO Committees and groups that deliberated about psychoactive substance use problems. These reports do not necessarily represent the decisions or the stated policy of WHO, they, however, express the view of international expertise and its evolution, over a period of 50 years. In addition to bibliographic references, this chapter provides cross-references to establish the relationship between health and legal approaches to treatment and rehabilitation.

Since the First World Health Assembly assigned high priority to the health problems due to *alcoholism and drug addiction* (World Health Organization, 1973a), these problems remained an important public health concern. The Assembly called for the establishment of both an Expert Committee on Mental Health to regularly review the health consequences of psychoactive substance use, and an Expert Committee on Habit-Forming Drugs, which was required to advise the United Nations on the habit-forming character of drugs with a view to their control under the 1925 and 1931 Conventions (World Health Organization, 1973b). In 1969 the functions of these Expert Committees were taken over by the WHO Expert Committee on Drug Dependence (World Health Organization, 1969), which continues to hold sessions.

In 1949, the Expert Committee on Mental Health asserted the public health nature of alcohol- and drug-related problems, and noted that the growing number of available *addiction-producing drugs* made them doubt whether control measures alone could ultimately keep the problem in check, let alone eradicate it (new drugs are described in section 2.1.1). The Committee believed that control measures must be supplemented by an active programme devoted to the study of the phenomenon of drug addiction as a problem in preventive medicine (World Health Organization, 1950). In 1996, the Expert Committee on Drug Dependence was requested to advise WHO on current approaches to treatment in a changing world (World Health Organization, 1998a).

#### 3.2 Use of terms

A starting undertaking for WHO was to define and classify the varied disorders, diseases and disabilities associated with the consumption of alcohol and drugs. The first result was the definition of an *alcohol dependence syndrome* (World Health Organization, 1964a,b), and the recognition of a wide range of health conditions related to alcohol consumption, which need not necessarily imply the presence of the alcohol dependence syndrome, these conditions could be physical, psychological, or social.

This development in the field of alcohol facilitated the action on substances that, following the international conventions (the Single Convention on Narcotic Drugs, 1961; the Convention on Psychotropic Substances, 1971), are also known as *illicit drugs* due to the legal controls over their production, trade, possession and, in some countries, their use as well. These substances include the narcotic drugs and the psychotropic substances as listed in the international conventions. Although such substances are not similar to alcohol, it became evident that they shared with it the risks of inducing the same range of health conditions.

Subsequently, terms such as *alcoholism*, *addiction* and *habituation* were replaced by the diagnostic category of *dependence syndrome due to the use of psychoactive substances* (World Health Organization, 1992a and 1992b). The 16th WHO Expert Committee on Drug Dependence defined drug dependence as "a state, psychic and sometimes physical, resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug" (World Health Organization, 1969). This definition has been widely accepted, and is consistent with the clinical description and guidelines for diagnosing the dependence syndrome in *The ICD-10 Classification of Mental and Behavioural Disorders, Clinical Descriptions and diagnostic guidelines* (World Health Organization, 1992b).

Another term included into the international classifications is *psychoactive substance*, which encompasses alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine, other stimulants including caffeine, hallucinogens, tobacco, volatile solvents and other. *Psychoactive substance* is a classification category based on the pharmacological properties of the substances, it includes the *drugs* controlled by the international conventions, as well as other substances that, when ingested, affect mental processes, e.g. cognition or affect (World Health Organization, 1994b). The word *drug*, at the ICD-10, is used in its medicinal meaning, however, the term *drug abuse* is frequently used in connection with the international conventions (chapter 5) and drug legislation and policies (World Health Organization, 1992a, 1994b, 1998a). The term *harmful use*, defined as a pattern of use that causes damage to health, should be preferred to *drug abuse* (World Health Organization, 1993c, 1994b, 1998a).

Bringing clarity to definitions and the classification of the health problems associated with the use of psychoactive substance use is a crucial contribution that WHO has made to this field. Diagnostic criteria were developed with a sensitivity to different cultures and diagnostic traditions; clinical and epidemiological instruments were produced and tested, lexicons of terms were compiled and given shape. This work culminated in a cross-cultural applicability research (CAR) of criteria for the diagnosis of psychoactive substance use disorders and of instruments for their assessment. WHO built up a common cross-cultural framework of concepts, which has

provided a fertile ground for comparative and interdisciplinary research. These developments, however, are rarely reflected in national policies, legislation and programmes (section 9.14, particularly 9.14.7).

At its thirty-first meeting, 23-26 June 1998, The WHO Expert Committee on Drug Dependence (World Health Organization, 1999) observed -

*The Committee has from time to time identified inconsistencies in substance abuse nomenclature as reflected in the Schedules of the 1971 convention [on Psychotropic Substances]. A question of possible confusion between acronyms used to designate substances in Schedule I of the 1971 Convention was raised in the discussion of the nomenclature of substances under control ... The lack of clarity arising from these two matters has led to conflicting interpretations of the Schedules and to varying degrees of precision in designating psychotropic substances for scheduling. To rectify this situation, the Committee recommended review of the nomenclature of all substances in the 1971 Convention by the appropriate international bodies. Such a review should take into account similar inconsistencies in the 1961 and 1988 Conventions.*

### **3.3 Definition of treatment**

The WHO Expert Committee on Drug Dependence noted, in 1970, that it is often difficult to separate concepts of treatment from those of rehabilitation and thus the word treatment should be understood as including rehabilitation (World Health Organization, 1970).

The term *treatment* is used to define the process that begins when psychoactive substance users come into contact with a health provider or service, and continues through a succession of specific interventions until the highest attainable level of health and well-being is reached. Treatment and rehabilitation are defined as a comprehensive approach to identification, assistance, health care, and the social integration with regard to persons presenting problems caused by the use of psychoactive substances. This definition recognizes the entitlement of users to be treated with humanity and respect (compare with section 9.14.5).

The definition uses the broad concept of rehabilitation adopted by United Nations agencies (ILO, UNESCO, WHO, 1994). It includes the equalization of opportunities and community involvement (compare with section 9.14.6). The aim of treatment, within this broader context, is to improve the health and quality of life of persons with problems caused by their use of psychoactive substances (World Health Organization, 1998a).

It should be highlighted that although brief and simple treatment interventions are effective in a number of cases, treatment and rehabilitation may also consist of a process sometimes extending over several years, as it is recognized that persons who have been using psychoactive substances for years will not return to normal shortly

after treatment has been started (World Health Organization, 1970). Therefore, rehabilitation and sustained care may be the most important phases of treatment for protracted, problematic users. It has been noted, however, that whereas jurisdictions in many countries have enacted laws providing for the compulsory and voluntary admission to withdrawal treatment (*detoxification*), they have given much less attention to, and provided almost no legislation for, rehabilitation (World Health Organization, 1962b).

### 3.4 Aims and objectives

There are three aims in treating and rehabilitating person with problems caused by their use of psychoactive substances:

- \* To reduce the demand for and the dependence on psychoactive substances.
- \* To reduce the morbidity and mortality caused by, or associated with, the use of psychoactive substances.
- \* To ensure that users are able to maximize their physical, mental and social abilities, have access to services and opportunities, and achieve full social integration.

In some countries, formal treatment programmes that receive public support are expected to achieve additional objectives, including a reduction in criminal and antisocial behaviour, a decrease in users' dependence on public welfare support, and an increase in productive legitimate activities. Different countries and localities within countries may give different priorities to these various objectives (section 7.1 - 7.2.6). Moreover, treatment agencies may differ in the priority they attach to these objectives, some focusing exclusively on reducing the consumption of psychoactive substances, and others giving greater weight to lowering morbidity and improving the quality of life (World Health Organization, 1998a).

While studies demonstrate that treatment reduces drug use, criminal activity, high risk behaviour, and welfare dependency (United States, 1998a), and that treatment is effective, the ideal goal, namely total abstinence, independence, gainful employment, satisfactory social and personal adjustment, and emotional stability, is often not achieved. Consequently, intermediate objectives have been formulated to evaluate treatment outcome which do not include abstinence, but rather improvement in the areas of health, economic stability and employment, social adjustment and decreased criminality (World Health Organization, 1970).

Withdrawal and subsequent abstinence can be seen as one aspect of the total treatment and rehabilitation programme and may be delayed in clinically justifiable circumstances (World Health Organization, 1970). There are circumstances where it is



imperative to facilitate the provision of health services to users who are not able to give up their drug dependence, and pose a threat both to themselves and to the society at large, e.g. HIV-seropositive substance users who spread the infection by sharing needles with other users, and through sexual activity with both users and non-users.

In this connection, the 28th Committee noted that the concept of harm minimization or harm reduction had recently become popular in some countries (section 2.2). This approach is aimed at achieving intermediate objectives as a half-way stage to achievement of the ultimate goal of freedom from drug dependence by using a variety of strategies to decrease the health risks of substance use. These include providing oral opioids as maintenance therapy (sections 15.2 - 15.3), and setting up needle and syringe exchange facilities (section 15.4) for injecting drug users (World Health Organization, 1993c).

In the light of these considerations, the Committee recommended that, national policies (sections 7.1 - 7.2.6) should focus on to explicitly defined goals, with both short-term and long-term objectives (World Health Organization, 1993c).

### **3.5 Treatment interventions**

In 1996, the WHO Expert Committee on Drug Dependence noted that the intervention strategies directed towards improving drug dependence fall into three main groups: professional treatment (requiring specific training); non-professional support structures; and informal self-help and mutual help activities. While some conditions are most frequently dealt with in a non-professional or informal way, others require professional treatment. In many cases strategies are combined, either simultaneously or consecutively. The treatment approach employed should be determined by individual diagnosis of pathological states and conditions. Accurate and comprehensive assessment is therefore essential in order to plan treatment tailored to individual needs, taking into account any factors that support consumption (compare with sections 9.1 - 9.13).

It should be reminded that the syndrome of dependence, while a matter of serious concern, constitutes only a narrow band of the whole spectrum of causes and consequences of alcohol and other drug use, all of them deserving special recognition and assistance (World Health Organization, 1980). However, most of the countries target their treatment systems, including policies, laws and programmes, to persons affected by the syndrome of dependence on alcohol and drugs (section 9.14). Treatment interventions for other clinical conditions, drawn broadly from the ICD-10, that were described at the 30th WHO Expert Committee on Drug Dependence, are dealt with below (World Health Organization, 1998a).

### 3.5.1 *Acute intoxication*

Acute intoxication by psychoactive substances can be followed by various health risks and complications related to the properties of the substance used, contaminating substances, dosage, specific vulnerabilities in individuals, route and rate of administration, context of use, and behaviour associated with use.

These risks and complications may be dealt with in the community (including the substance use setting) or in outpatient and inpatient settings according to the gravity of symptoms and the need for medical infrastructure. Informal and non-medical monitoring and care of acutely intoxicated persons can be helpful, but in cases of overdose or pathological reactions, including disturbed behaviour, professional assessment and treatment are indispensable.

Pharmacological methods are sometimes used to minimize health risks and complications; they include the use of antagonists or medication to reduce the pathological symptoms. They are specific to the substance used or the symptoms displayed. Psychosocial support is essential in order to motivate the recovering individual to improve on dangerous consumption patterns and to identify the next steps that might appropriately be taken. Nevertheless, treatment for acute intoxication must be provided without making prolonged care a requirement.

Careful supervision of intoxication states, guarding against accidents due to disturbed behaviour and preventing death or permanent damage from overdose, are the most important and effective elements of intervention. Such interventions are often undertaken within the community by peers, family members and others, without the formal involvement of health care professionals or treatment services. Interventions aimed at avoiding recurrences may be considered for persons who have experienced drug overdoses.

### 3.5.2 *Harmful use*

In accordance with the definition used in the report of the Committee's twenty-eighth meeting (World Health Organization, 1993c), harmful use is defined here as "a pattern of psychoactive substance use that causes damage to health, either mental or physical". By hazardous use the Committee understands consumption patterns with considerable risks for negative health and/or social consequences.

An assessment of consumption patterns, and especially high-risk patterns, is essential whenever hazardous/harmful substance use by an individual is suspected. Assessment must include a diagnosis of adverse health effects and conditions that require treatment. It should also include an identification of risky conduct such as aggressive behaviour or disinhibited sexual behaviour under the influence of substances.

Early detection of harmful use is essential whenever an individual using dependence-producing substances initiates contact with medical or social services for reasons that may be connected to substance use. Some countries provide injecting drug users, especially those who persist in injecting, with sterile injecting equipment in order to reduce the risk of harmful consequences (compare with section 15.4).

Whenever harmful use is diagnosed, brief interventions should be considered. They are helpful in cases of use of alcohol or tobacco but have not been properly evaluated for other substances, although there are some indications that they can be useful.

In many instances information and counselling on how to replace high-risk consumption patterns with less risky patterns must be considered. For example, drug injectors may be advised to use other routes of administration, and tobacco users to replace cigarettes with nicotine patches.

### 3.5.3 *Dependence syndrome*

The dependence syndrome is a cluster of physiological, behavioural and cognitive phenomena of variable intensity in which the use of a psychoactive substance (or substances) takes on a higher priority for the individual than other activities. The necessary descriptive characteristics are preoccupation with a desire to obtain and take the drug, and persistent substance-seeking behaviour. The determinants and problematic consequences of substance dependence may be biological, psychological or social; they usually interact.

Wherever a dependence syndrome is diagnosed, the main means to overcome it are psychosocial and behavioural interventions aimed at a substance-free lifestyle. These approaches may be supported by pharmacological methods. Such methods may include substitution of a less harmful form of a substance for shorter (e.g. tobacco) or longer (e.g. opioids) periods.

In many cases, such forms of treatment are not feasible for various reasons. Intermediate goals aiming at harm minimization may then be considered according to the individual's priority needs, the major harms involved, and the particular circumstances that may affect compliance and a positive treatment outcome.

### 3.5.4 *Withdrawal state*

A withdrawal state occurs when the intake of a psychoactive substance is discontinued, spontaneously or in detoxification procedures. Withdrawal of substance has specific risks according to the substance involved. Withdrawal of barbiturates, alcohol and benzodiazepine in particular may produce serious or even life-threatening complications, which may also occur with opioid withdrawal in debilitated persons.

Management of withdrawal state and all detoxification programmes should take such risks into consideration. Appropriate supervision is needed and medical services should be available, especially in the presence of confusional states, cerebral seizure or hazards as a consequence of poor nutritional condition. Adequate monitoring has an essential part in the management of withdrawal state. Pharmacological treatment and other methods such as physiotherapy, herbal teas or acupuncture can be used to relieve pain, unrest, sleeplessness or other symptoms. Decreasing dosages of a substitute substance may be administered for a few days, especially in cases of barbiturate, alcohol, benzodiazepine and opioid dependence.

Successful treatment of withdrawal state does not prevent the continuation of substance use. Relapse prevention methods must be considered, according to their availability and acceptability for the individual concerned. Informal self-help structures and nonprofessional support may be helpful; in other cases professional intervention is indicated to prevent relapse.

### **3.5.5 *Related psychiatric disorders***

A range of psychiatric disorders occurs as a consequence of harmful/dependent substance use or as a pre-existing condition. These include paranoid psychosis, depression and other mood disorders, amnesic syndrome, confusional states ( including flashbacks), personality disorders and somatization disorders.

Such psychiatric conditions need professional diagnostic assessment and therapeutic intervention, either in the primary health care setting or by specialists. They should be given state-of-the-art treatment regardless of their status as a primary condition, a concomitant disorder, or a consequence of substance use. Abstinence from substance use is indicated when use is a causative factor in the diagnosed disorder. Treatment of pre-existing disorders that have prompted the use of a psychoactive substance as a form of self-medication often leads to cessation or reduction of use.

Simultaneous and appropriate treatment of co-existing psychiatric disorders and alcohol-and-drug related disorders in the individual patient, however, may be hindered in some countries when entitlements to human rights and treatment are not the same for mental patients as for alcohol and drug users (sections 14.1 - 14.4).

### **3.5.6 *Other somatic disorders***

Somatic disorders in substance users may be a consequence of harmful use or independent of it. Different substances have different risks for producing somatic disorders, which include cirrhosis of the liver in chronic alcohol dependence and emphysema in chronic tobacco smoking. When such disorders are a consequence of use, abstinence from the substance used is again therapeutically indicated. Other somatic disorders should be treated according to current best practice. Whether or not

abstinence is achieved, somatic conditions must be treated. This applies particularly to infectious diseases, including sexually transmitted and HIV-related diseases, hepatitis and tuberculosis.

Somatic disorders call for professional treatment, in primary health care settings or by specialists. Motivation to undertake and comply with that treatment can be enhanced through non-professional support, including involvement of the patient's family and other supportive measures.

### **3.5.7 Chronic disabilities**

Substance use may result in chronic conditions that impair psychosocial functioning, physical health and quality of life. Such conditions require long-term management and rehabilitation. While some are reversible, others are not. Proper assessment is necessary in order to plan individual treatment and provide, to the extent possible, a supportive and non-stigmatizing environment (e.g. through community involvement, guidance to and by the family, and sheltered living conditions). Such interventions should be equally available if substance use continues (compare with sections 14.2, 14.3, and 14.4).

Informal self-help initiatives, non-professional support and professional rehabilitation methods can all be useful, whenever they are appropriate to meet the individual needs of the person involved (World Health Organization, 1998a).

## **3.6 Treatment evaluation research**

The treatments that are actually offered to people with drug and alcohol problems include an almost unimaginably diverse range of interventions. Among those which have been used are medical detoxification, supportive counselling, brief interventions, videotaped self-confrontation, motivation interviewing, hypnosis, cognitive therapies, behavioural counter-conditioning treatments, relaxation therapy, prescriptions for psychotropic drugs such as benzodiazepine tranquillizers, drug-free rehabilitation houses, family counselling, needle and syringe exchange schemes, Alcoholics Anonymous and Narcotics Anonymous, and substitution drug maintenance. This list is far from exhaustive. Such diversity of approaches may differ in modality, philosophy, stage specificity, setting, target, provider, time-frame, efficacy, cost, availability, utilization, organizational characteristics and financing, all of which require consideration. Proper evaluation studies are, however, lacking for most of the types of treatment (World Health Organization, 1993i). The theme of treatment evaluation was particularly considered at the 30th WHO Expert Committee on Drug Dependence where it was noted that the above dimensions must be clearly defined when attempting to evaluate treatment under controlled conditions (compare with sections 2.1.3; 7.2.2; 8.2; 8.3).

The randomized clinical trial can be regarded as the most robust method of treatment evaluation. The strength of evidence from different sources can be ranked as follows:

1. Multiple well designed randomized clinical trials.
2. Evidence from well designed studies with some element of control present.
3. Evidence from well designed non-experimental studies, e.g. observational or follow-up studies.
4. Evidence based on the opinion of respected authorities and expert committees or on individual anecdotes derived from acknowledged experience.

The evaluation of well defined interventions by randomized controlled trials provides the strongest evidence of benefits. In the past two decades there have been a number of randomized controlled trials of treatment in the field of tobacco, alcohol and other psychoactive substance use. Such experimentally designed trials in the tobacco field have helped to clarify issues of treatment efficacy in tobacco cessation and have resulted in the elaboration of detailed guidelines for the treatment of smoking, especially in combination with available pharmacological supports such as nicotine substitution. The guidelines provide a model for similar activities in all areas of treatment for alcohol and other drug dependence. There have also been a considerable number of carefully controlled randomized double-blind studies of pharmacological treatment for alcohol, opioid and stimulant dependence.

However, while such structured and quantified forms of evaluation provide weighty evidence of the benefits of treatment, the Committee also recognized the value of other research methodologies such as controlled observational studies, longitudinal studies and qualitative research, which provide invaluable information on complex treatment approaches that cannot be studied in experimentally designed trials. There has also been a significant growth in the number of multi-centre trials, longitudinal cohort studies and other outcome-type studies which have done much to provide information about existing treatment methods. For example, between 1980 and 1990 more than 250 new studies were published that reported outcome data on various aspects of alcohol treatment. A wide range of effective treatment is available for alcohol and drug problems, including psychosocial, medical and educational interventions, and a large body of research has demonstrated that treatment for alcohol and drug problems can be effective.

The need remains, however, for significant continuing investment in the design and execution of experimental trials in the field of psychoactive substance

dependence if more definitive statements about the value of specific treatment approaches are to be made with confidence.

There is often a substantial lag in putting into practice what is learned even from well designed studies. The recent emphasis on health services research in many countries offers important possibilities for improving the links between research and practice. The focus here is on applying clinical research findings to real world settings in order to assess their effectiveness. In addition, much has been learned about how the financing system, health service organization, and treatment process affect access and outcome.

In most countries there is a significant gap between what is known about effective treatment and what is delivered. Much of what is done has not been evaluated, and in many areas where the generally scarce resources for treatment are available there may be major expenditure on expensive but less effective treatment rather than briefer and more cost-effective approaches. The Committee pointed to the need for such gaps between knowledge, policy and practice to be narrowed over time (World Health Organization, 1998a).

In 1970, the WHO Expert Committee on Drug Dependence had advised that changes in legislation and policy should be seen as a welcome opportunity to introduce experimental methods in public health (World Health Organization, 1970), this recommendation, however, is only recently beginning to be implemented in a few countries (compare with sections 8.1-8.3).

In addition to the efficacy of particular interventions, questions may also arise regarding the economic evaluation of psychoactive substance use treatments. This questions have led to investigations aimed at determining whether treatments for substance use disorders and dependence, particularly those for internationally controlled substances and alcohol, yield benefits that equal or exceed their costs. The procedure for such *cost-benefit studies* is to measure all the costs and benefits that arise from treatment compared to the costs and benefits that would occur if there were no treatment. Measurement is usually based on the differences between treatment and no treatment, but similar analyses can be used to compare different types of treatment. Another simpler version of a cost-benefit study is what has been termed the *cost offset study*, in which the cost of treatment is compared to the saving in health care costs.

The results of such studies should be relatively clear-cut. If a treatment programme results in more benefits than costs, then treatment can be considered worthwhile, since society would be worse off if no treatment were available. To go further, and to suggest that additional expenditure on treatment is desirable, would need further analysis to evaluate the costs and benefits of providing the additional resources (compare section 8.3).

The Committee noted the considerable number of studies that had been undertaken to examine the costs and benefits of treatments for alcohol and other substance use. It therefore expressed its concern that, at a time when the effectiveness, and indeed the cost-effectiveness, of treatment has been established, the availability of many of the treatments has been decreasing. For example, reductions in the number of services provided, length of stay, and intensity of treatment have been found in both public and private programmes in some countries during the past 10 years (World Health Organization, 1998a)

### **3.7 Social and cultural factors**

The area of treatment and rehabilitation of alcohol and drug-related health conditions is more often than not at the mercy of political cross-currents, contradictory traditions and economic interests. These and other social factors often hinder the development of comprehensive policies and programmes, reduce the availability of services, and make it difficult for alcohol and drug users having access to health services because of discrimination, stigma, or lack of incentives and adequate information (World Health Organization, 1998a).

However, the political decisions of particular governments and administrations can now be contrasted with the results of scientific research and steadfast empiricism to promote public health approaches in the pursue of WHO objective, i.e., the attainment by all people of the highest possible level of health. The inclusion of all persons with problems caused by their use of psychoactive substances into this objective is, however, still a task to be accomplished, particularly in some countries where users are seen as criminals and discriminated against, or because of traditions and economic interests that encourage the use of some substances, like alcohol and tobacco.

WHO publications highlight the importance of integrating prevention and treatment of these problems into the primary health care as the principal strategy for achieving universal access to services as well as equity and quality in health. Several studies in individual countries have demonstrated the benefits of enlisting existing community services in the management of the adverse health consequences of psychoactive substance use (see chapter 4).

WHO has also emphasized the need to be aware of the sociocultural context in which problems caused by psychoactive substance use occur (see section 1.4.5). In 1966, the Committee noted that, a number of beliefs and moral attitudes towards the use and effects of certain substances influence both, the effects of drugs and the outcome of treatment (World Health Organization, 1966). There are a range of examples where a programme that is effective in one culture may be completely ineffective in another.



As reported by the WHO Study Group on Youth and Drugs, the challenge is to establish policies and programmes that reduce the damaging effects of substance use to the lowest possible level without undue detriment to society. Unawareness of these facts lead to negative attitudes that may encourage either punitive responses or none at all, rather than a neutral approach or responses designed to help persons in trouble (World Health Organization, 1973c).

The loss or distortion of normal social support is particularly unfortunate when substance-use leads to discriminations and stigmatization that excludes the user from the remainder of society (see sections 14.9, 14.13, and 14.14). This reaction may be disastrous for users, since they are often denied access to health services, normal work and recreational opportunities (World Health Organization, 1974). In view of the emergence of AIDS and its association with psychoactive substance use, the 28<sup>th</sup> Committee noted the fact that users who are infected with HIV and capable of transmitting the disease might be marginalized from health care (World Health Organization, 1993c).

The high rates of HIV infection and AIDS among substance-users, and particularly injecting drug-users, has further increased the need for appropriate legal and medical responses. The 28th Committee (World Health Organization, 1993c) noted that the use of psychoactive substances has facilitated the spread of HIV infection in several ways, the most direct of which is by the transmission of HIV through needles shared by injecting substance-users. Another common mode of HIV transmission is through sexual contact, sometimes alcohol use is related to unsafe sexual activity, and many users have engaged in prostitution in order to enable them to purchase psychoactive substances.

The transmission of HIV infection can be reduced by educating injecting users in the sterilization of needles. In some countries, sterile needles and syringes and condoms are provided, as well as oral methadone maintenance treatment (World Health Organization, 1993c). Although such measures may be controversial, they should at least be considered as part of a broad public health approach aimed at reducing the burden of psychoactive substance use-related harm (see section 9.11, and chapter 15).

Another barrier to the development of treatment programmes is the unwillingness of some governments to support programmes dealing with socially accepted psychoactive substances, particularly tobacco and alcohol, which are a source of revenue.

Similarly, the tobacco, alcohol and other drug industries often have interests contrary to those of users in need of treatment. For example, giving a high profile to the beneficial effect of light drinking on cardiac mortality may persuade the heavy drinker to postpone seeking treatment. The promotion of *modified* low-alcohol beverages in soft drinks form and/or mixed with caffeine may be targeted at a younger population and encourage inappropriate consumption. The many subtle and not-so-subtle

instances where the activities of such vested interests impede treatment-seeking behaviour need careful attention and study (World Health Organization, 1998a).

Taking into account the contrast between discrimination against users of illicit drugs and promotion of the use of some drugs, like alcohol and tobacco, and recognizing that people consume many different psychoactive substances, both licit and illicit, the Expert Committee on Drug Dependence has advised that attempts should be made to consider the health problems due to alcohol and other drugs together (World Health Organization, 1967, 1971, 1974, 1980).

The 28th report of the Committee acknowledged that public health approaches to all psychoactive substances, including alcohol and tobacco, are increasingly being viewed in a common frame in many countries, in what is called the *combined approach*, treatment services may frequently be located in a single administrative structure, although the services may retain their specificity. In addition, patients using those services often require treatment for more than one substance-related problem. All these factors have pointed to a convergence in policy-making about psychoactive substances. In Australia, for instance, a national drug offensive which initially focused almost solely on illicit substances, now puts its strongest emphasis on alcohol and tobacco because of their greater health burden on the Australian population (World Health Organization, 1993c).

### **3.8 Involuntary entry for treatment**

These issues are extensively considered in other sections (section 2.1.2, chapters 10, 11, 12 and 13). The 30th report of the Committee (World Health Organization, 1998a) recognized WHO's longstanding concern that substance use may be treated as a legal instead of a health problem. For example, a WHO Study Group noted in 1956 that, in certain societies and countries, the dependent user may by law be classed as a criminal. In such instances, it was recommended that he/she should, if possible, have all the benefits of adequate medical care (World Health Organization, 1957). Similarly, a WHO Expert Committee on Mental Health recommended in 1966 that in legislation on persons dependent on psychoactive substances, it should be recognized and stated that these are sick persons, and the legislation should require the control and judicial authorities and the therapeutic agencies to work together (World Health Organization, 1967).

In 1973, the WHO Expert Committee on Drug Dependence observed that the responsibilities of the various official agencies for different aspects of the management of problems associated with the use of psychoactive substances are ordinarily defined by laws and regulations (section 9.4). In some countries, the responsibility both for controlling the availability of psychoactive substances and for managing the users is assigned largely to law-enforcement and prison agencies. In others, health and welfare

agencies are given the major responsibility for the treatment and management of most users of psychoactive substances (World Health Organization, 1973d).

These questions were again considered by the 28th Committee. The Committee observed that in some countries, high rates of drug-related arrests have affected the nature and quality of treatment for substance-use problems, and that in many countries prisons had become overcrowded and numerous studies had reported very high levels of dependence on nicotine, alcohol and other psychoactive substances among prison populations. The Committee encouraged WHO to promote research directed at exploring the feasibility and consequences of programmes that divert those arrested for the use of psychoactive substances from the prison system to the health-care system, and recommended that further evaluation of interventions within the prison system be conducted. It also recommended that, whenever imprisonment is employed, mechanisms to safeguard the human rights of psychoactive substance users should be in place, as should mechanisms to reintegrate users into the community (World Health Organization, 1993c).

In the light of that history, the 30th Committee, expressed concern that, although the lack of therapeutic attention to substance users in the criminal justice system had been raised as a serious problem since 1957, the situation had not improved. While drug-dependent persons may be imprisoned because of unlawful activity associated with their drug dependence, it remains urgent that dependent and harmful use of substances be considered as a health problem and treated accordingly. In addition to human rights concerns, appropriate treatment is also important because of the spread of HIV infections, AIDS and hepatitis C among inmates. In most countries, despite the high prevalence of psychoactive substance use problems within the prison system, the provision of treatment within the prison setting is minimal.

With regard to voluntary and compulsory treatment, the 1957 WHO Study Group on the Treatment and Care of Drug Addicts observed that, for cooperative drug dependent persons, there should be provision for complete treatment outside as well as inside institutions. However, it will occasionally be necessary to resort to coercion before the patient can be made to undergo treatment. As far as possible, the user should be allowed to make a free decision, so that from the beginning some degree of cooperation may be obtained and treatment may be based on a sense of trust (World Health Organization, 1957).

In 1966 the WHO Expert Committee on Mental Health advised that, for compulsory treatment to be of value, the basic legislation should be preventive and therapeutic in its aim, public opinion must be in agreement with this aim, and ample services must be available (World Health Organization, 1967).

With respect to the role of compulsion in the treatment of persons dependent on alcohol and other drugs, the WHO Expert Committee on Drug Dependence reported that clinical evidence was not sufficient either to support or to refute the case for

various forms of compulsory treatment, but noted that, in spite of considerable experience, compulsory detention alone had not been shown to be beneficial (World Health Organization, 1970).

However, coercive measures can be more effective under some circumstances. For example, studies of some occupational groups, e.g. doctors and pilots, indicate that urine testing linked to mandatory abstinence with serious negative sanctions for breaches can result in high levels of long-term abstinence. Those who fail to attain this level of abstinence suffer serious negative occupational and social consequences. This contingency arrangements are typically linked with referrals to mutual help groups such as Alcoholics Anonymous (World Health Organization, 1998a).

In any case, the Committee took the view that assuring the conditions to promote health and reduce harm must take precedence over every other consideration. Policy-makers should therefore proceed with caution before curtailing human rights that may influence peoples's health and well-being. However, the Committee noted that many types and levels of coercion are associated with the treatment of substance use problems, and that most individuals enter the treatment system through some form of coercion. These include social pressure from family and friends, pressure from the workplace, diversion from the criminal justice system, in-prison programmes, and commitment to treatment under civil law. Countries differ with regard to confidentiality for patients receiving treatment through the various referral mechanisms. Confidentiality in treatment is an important area of medical ethics that merits continuing consideration.

The Committee considered that it is of utmost importance to guarantee confidentiality and to provide ethical and effective treatment to these populations. It also emphasized the importance of placing treatment under the jurisdiction of the health services (World Health Organization, 1998a).

### **3.9 Planning of treatment programmes**

Treatment responses range from generic community responses provided by, for example, traditional healers and community development workers to specialized services for the chronically ill. In this context there is a need to consider the broad aspects of information provision and access to information. New technologies, such as Internet, offer the potential for providing more accessible and accurate information on a range of possibilities. The strategies adopted for developing treatment should permit access to the whole population and the means to meet its needs, in accordance with WHO's goal of Health For All. Research is needed to examine the context and design of programmes and to find models that are affordable for the developing countries.

It has to be considered that, in the same way that treatment of the drug-user should be regarded as a long-term process, with intermediate goals, so that the

development of treatment programmes and systems should take place in stages. Different countries will develop services in different ways, the aim should be to employ a variety of treatment methods appropriate to the different needs of users and the different stages of treatment, rather than any single approach applied in isolation.

The main issue to be dealt when planning treatment programmes should be to ensure access to care for all in need, including marginalized, itinerant and hidden populations. A condition for assessing ease of access is that sufficient appropriate services should be available. However, even when treatment services are available, some persons with problems due to the use of psychoactive substances may experience difficulty in having access to them because discrimination, stigma, or lack of incentives and adequate information. Most current research argues for multiple levels of explanation: individual, organizational, and sociocultural factors all come together to affect access.

The Committee emphasized the desirability of providing appropriate environmental conditions for treatment. Resources should be devoted to encouraging contacts between users and the health services, and every effort should be made to enlist community agencies to assist users in community adjustment. It is in the community that addiction starts and it is there that problems should be identified and the later stages of rehabilitation, adjustment and adaptation should be carried out. There should be provision legal and otherwise, for treatment in home, health centre, or outpatient clinic, as well as for contacts with the social and other community services (World Health Organization, 1957, 1973d).

The Committee noted that, in a number of countries, there has been strong emphasis on action at the community level to prevent the use of psychoactive substances and reduce substance-related problems (see chapter 4). Basing prevention and treatment interventions in the community brings public health action to the level of people's everyday lives and actions. It therefore conforms the WHO's emphasis on strengthening primary health care as the first level of contact of individuals, the family and community with the health system, bringing health care as close as possible to where people live and work and constituting the first element of a continuing health care process.

Action at the community level is also important since communities often bear the main burden of the harm caused by psychoactive substance use. Accordingly, attention should be given to the way in which the treatment services and the health system respond to community needs, support community aims, and draw support from all parts of the community. General practitioners, primary health care workers, pharmacists, social workers, and other community health agents should be trained to screen and detect problems due to the use of psychoactive substances, to make contact with users, to encourage them to seek help or continue treatment, and to deliver care. An important location for treatment interventions is the primary health care centre, particularly in developing countries, where both resource constraints and the likelihood

of increased stigma militate against developing vertical specialized programmes. Self-help organizations should also be involved.

Social factors at the community level should be carefully assessed and discussed with community leaders, not only to remove resistance and change attitudes, but also to recruit the much needed support to back up sustained treatment and efforts. When the community is informed about what treatment is on offer and what it seeks to achieve, drug-users are encouraged to seek help and the stigma associated with treatment may be removed. Such an approach assists the reintegration and rehabilitation of treated drug-users into the community. The special needs of health personnel and community leaders who have themselves developed drug-related problems may also need to be considered.

Furthermore, members of the drug-user's family are likely to experience a variety of adverse psychosocial, economic or health consequences of drug use. The longer the affected person remains untreated, the greater will be the burden of family suffering. Ready availability of help for the drug-user is thus in the interest of the family, as well as of the user.

To sum up, access to services is dependent upon their availability. Priority needs to be given to a wide population-based approach to treatment provision when arriving at the balance between primary care and specialist services. Guarantees of confidentiality (section 14.5) are important to ensure that fear of disclosure is not a barrier to seeking treatment (World Health Organization, 1993c, 1998a).

### **3.10 Treatment, prevention and demand reduction**

The first WHO Expert Committee on Mental Health recommended that responses to alcohol- and drug-related problems must be seen as a part of preventive medicine (World Health Organization, 1950). The discussions on this theme have been summarized in the following terms: Treatment systems, especially when viewed from a public health and population-based perspectives, can be seen as part of the prevention continuum. *Primary prevention* is aimed at ensuring that a disorder, process or problem will not occur; *secondary prevention* is aimed at identifying and terminating, or modifying for the better, a disorder, process or problem at the earliest possible moment; and *tertiary prevention* is aimed at stopping or retarding the progress of a disorder, process, or problem and its sequelae even though the basic condition persists.

While the term secondary prevention usually refers to treatment and rehabilitation interventions at a stage when psychoactive substance use has not yet caused serious problems, tertiary prevention refers to strategies for reducing the harm to and improving the quality of life among users who may experience physical and mental disabilities, as well as social disadvantages. The Committee considered that such an approach requires both immediate interventions in acute cases and longer-term

interventions when chronic rehabilitation is appropriate for persons with severe dependence and related social disabilities (World Health Organization, 1974, 1993c, 1998a).

Understanding and applying preventive medicine as a comprehensive public health approach to psychoactive substance use-related problems is the key for influencing the market and reducing the demand for alcohol and drugs. In this connection, the 29<sup>th</sup> WHO Expert Committee on Drug Dependence had noted that although the international conventions appear to address adequately illicit supply and trafficking, they give less attention to demand reduction, and the imbalance in these conventions ought to be addressed (World Health Organization, 1995a) (compare sections 5.1, 5.2, 5.3).

Such concern has been dealt with by the United Nations General Assembly's Declaration of the Guiding Principles of Drug Demand Reduction, where it was declared that: Programmes to reduce the demand for drugs should be part of a comprehensive strategy to reduce the demand for all substances of abuse. Such programmes should be integrated to promote cooperation between all concerned, should include a wide variety of appropriate interventions, should promote health and social well-being among individuals, families and communities and should reduce the adverse consequences of drug abuse for the individual, and for society as a whole.(United Nations, 1998).

Treatment interventions may serve more than one purpose. For example, a programme designed primarily to reduce the sequelae in dependent users (tertiary prevention) may, through effective treatment of such users, lead to a substantial reduction in their use of substances, i.e, a reduction of their demand for psychoactive substances. To the extent that these users were formerly important sources of illicit drugs for other persons in their environment, tertiary prevention for them may have both a supply and demand reduction and a primary preventive effect for others. This effect also reduces the probability of progression in demand for and consumption of drugs, in those who have already begun experimentation (World Health Organization, 1974).

Further to this, a given effort must be viewed in more than one time-frame. Effective interventions targeted to dependent users in one generation may be viewed as tertiary prevention, but it may also act as a constructive method of reducing the demand for substances in a later generation by virtue of impact on the total social and legal environment. Certain maintenance or substitution treatment programmes may have a preventive impact on the spread of HIV infection, and a demand reduction impact on the environment entirely apart from their major intended goal of reducing the risks and easing the disabilities of the chronic users involved. In this sense, even programmes that substitute a substance of dependence obtained through medical channels for a similar substance obtained through illicit channels may serve to reduce *contagion* and

thereby *contain* or prevent further spread of that particular form of substance use (World Health Organization, 1974).

In order to reduce the demand for alcohol and other drugs, a careful debate is needed in some countries about a balanced and comprehensive approach to treatment and prevention programmes, as the two aspects of the response to problems arising from the use of psychoactive substances are synergistic, despite differences in the target populations, goals and delivery mechanisms (World Health Organization, 1993c).

Given the interrelationships between drug-users and non-users, between different substances, and between those at highest risk and those at lesser risk, it can be seen that intervention of a preventive nature is difficult to disassociate from intervention of a therapeutic, including rehabilitative, nature for some particular target groups; for example, the rehabilitation of individuals with chronic alcohol dependence who drive may eventually prevent loss of life for the non-drinking drivers who share the roads with them (World Health Organization, 1974). The rehabilitation and education in harm reduction of injecting drug users will, by the same token, prevent the spread of HIV/AIDS among sexual partners (World Health Organization, 1993c).

Although legal controls on the illicit drug market, and education and prevention measures may be sufficient to avoid health and social problems due to the use of psychoactive substances, it may happen that despite law enforcement, prevention and education, some people will develop harmful or dependent patterns of use. With many other demands on health care, however, there is a risk that the health problems caused by substance use may be accorded only low priority. In the planning and development of national demand reduction strategies, it is essential to include an appropriate treatment system, especially since untreated persons with problems caused by their drug use interact with and exacerbate many other health and social problems. Untreated individuals with these problems are also likely to overburden the courts and the prison system (compare chapter 9).

### **3.11 Conclusions**

The 30th WHO Expert Committee on Drug Dependence (World Health Organization, 1998a), after reviewing the previous WHO reports on treatment issues, provided WHO with a range of recommendations. Most of these recommendations are relevant to the study on policies, legislation and programmes on treatment and rehabilitation of alcohol and drug dependence. The text of the relevant committee recommendations is reproduced (3.11.1 - 3.11.5) below:

#### **3.11.1 Policy issues**

1. WHO should encourage countries to give equal attention to measures to reduce demand for psychoactive substances and to efforts to reduce their



supply. Greater emphasis should be placed on the treatment of persons dependent on psychoactive substances as a means of reducing demand, and health authorities should play a leading role in the formulation of policies concerning such treatment.<sup>1</sup>

2. WHO should work with countries to develop explicit policies regarding the provision of treatment for disorders due to the use of psychoactive substances.

### 3.11.2 *Treatment services*

1. WHO should give priority to developing a strategic plan for treatment services on the basis of a global assessment of the treatment needs of those experiencing health problems related to the use of psychoactive substances.
2. Noting that treatment under coercion is in widespread use and that there is significant advocacy of its even wider use, the Committee recommended that WHO should encourage analysis of the ethical issues raised by such treatment, and of the advantages and disadvantages of these different forms, including comparisons of the cost-effectiveness of enforced institutional treatment and less coercive community-based treatment.
3. The Committee noted the widespread adoption in many countries of the use of methadone and other similar substances for the management of opioid dependence. Such treatment is supported by ample scientific evidence of its benefits when delivered in well-controlled settings conforming to high standards. WHO should support the development of international guidelines to promote high standards of practice in well-controlled settings.
4. WHO should support efforts to improve the diagnosis and treatment of health problems due to the use of psychoactive substances, especially for persons with coexisting mental disorders.
5. In view of the rising prevalence in many countries of multiple substance use, WHO should support efforts to improve the treatment of persons with health problems due to the use of more than one psychoactive substance.
6. WHO should continue to seek ways of improving the access to treatment of population groups that are at high risk of developing health problems due to the use of psychoactive substances and have poor access to services. These include indigenous peoples, prisoners, young people, and refugees.

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<sup>1</sup> See discussion of National Advisory and Coordinating Bodies (section 8.1).

7. Greater efforts should be devoted to developing and implementing treatment measures to reduce the recidivism of persons convicted of driving while intoxicated with alcohol or other substances.
8. The Committee reiterated the recommendation made at its 28th meeting that WHO "should support its Member States in developing treatment services that can reduce the transmission of HIV<sup>2</sup> through needle-sharing or sexual activity among drug users"

### 3.11.3 *Training*

In conformity with the Organization's mandate under World Health Assembly resolutions WHA33.27, WHA42.20 and WHA43.11 to integrate the treatment of health problems due to the use of psychoactive substances into primary health care and other social services, the Committee recommended that WHO should support the training of primary health care and other community workers in the treatment of persons who are dependent on or have problems due to psychoactive substances.

### 3.11.4 *Dissemination of information*

Interventions to prevent or stop the negative health consequences of the use of psychoactive substances that are cost-effective and can reach large numbers of affected individuals should be described more fully and information about them be disseminated in training manuals and through computer technology.

### 3.11.5 *Research*

1. Given the desirability of reaching the greatest possible number of persons with health problems due to the use of psychoactive substances, the Committee expressed concern that some of the most commonly used interventions have not been evaluated for either efficacy or cost-effectiveness. The Committee accordingly recommended that further evaluation efforts should be focused on programmes located in primary health care settings and other community service agencies, as well as others that can reach large numbers of affected persons at low cost.
2. Treatment strategies that have been shown to be efficacious in clinical trials are not commonly found in developing countries. The Committee recommended that health services research should be undertaken to examine such treatment strategies in a range of countries. WHO should encourage

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<sup>2</sup> Author's note: as well as other blood-borne infections.

appropriate national research institutes to support collaborative research on these strategies, as well as on untested community-based methods.

3. WHO should encourage and support cross-sectional, longitudinal and other studies of persons with health problems due to the use of psychoactive substances, in order to identify those personal and social factors that facilitate the cessation of use and recovery from dependence. Such studies should also examine how messages promoted by the alcohol, tobacco and other legitimate industries may influence the natural recovery in treatment of those experiencing health problems due to the use of psychoactive substances, with a view to improving cessation rates around the world.
4. WHO should continue to support efforts to develop standard methods of cost and cost-effectiveness analysis of treatment for disorders due to the use of psychoactive substances. WHO should also continue to support the dissemination of these methods and case studies of their application.
5. WHO and national research centres should support international efforts to undertake systematic quantitative reviews of scientific studies on the effectiveness of treatment for disorders due to the harmful use of alcohol, tobacco, opioids, and other psychoactive substances, and should develop treatment guidelines in the light of the findings.



## **4. Community integration, employee assistance in the workplace and self-help**

As noted in the WHO guidelines (Curran, Arif & Jayasuriya, 1987), the integration of treatment services for drug and alcohol dependence with community health services may be advisable in many countries.

### **4.1 General**

Community services may well be associated with local primary health care services. The WHO guidelines (Curran, Arif & Jayasuriya, 1987) recommend that the legislative approach to drug- and alcohol-treatment programmes should also be developed in harmony with overall community health objectives and the trend away from the concentration of mental health resources in large hospitals and excessive reliance on highly trained professionals. Drug- and alcohol-treatment services have been developed in many countries at the local level, using alternative, much less expensive types of personnel and other resources. The WHO guidelines (Curran, Arif & Jayasuriya, 1987) emphasize that dependence is not a purely medical problem and that the traditional medical approach alone cannot provide an adequate framework for successful treatment or prevention. The community has an equally important part to play, and the health system should educate and motivate people to assume responsibility for their own health.

This approach has been reflected in the priorities for WHO's work in cooperation with countries to encourage healthy lifestyles and behaviour, with particular attention to alcohol and drug abuse, which have been adopted by the World Health Assembly for the Ninth General Programme of Work, covering the period 1996-2001 (World Health Organization, 1994a). The World Health Assembly has adopted several resolutions, e.g. resolution WHA 39.26 (World Health Organization, 1993g), encouraging the establishment and development of appropriate services for the treatment of patients with drug-related problems and their integration with existing health and mental health services, particularly at the primary health care level, and with those provided by social services and nongovernmental organizations. The World Health Assembly has also urged Member States in resolution WHA 43.11 (World Health Organization, 1993h), to promote effective treatment for drug-dependent persons, involving the full participation of the community and nongovernmental organizations.

As already mentioned, the integration of treatment services for drug and alcohol dependence with community health services may be advisable in many countries. Such community-based services may well be associated with other local primary health services. For this reason, treatment programmes will often be under the

authority of the ministry of health, although they may be coordinated by a national board for drug and/or alcohol control.

The community approach was reflected in the targets for the WHO programmes on the prevention and control of alcohol and drug abuse adopted by the World Health Assembly for the Eighth General Programme of Work, covering the period 1990-1995. As previously noted, in 1994 WHO published the Ninth General Programme of Work, covering for the period 1996-2000, as adopted by the World Health Assembly (World Health Organization, 1994a). One of the priorities mentioned in the Ninth General Programme of Work (paragraph 93) is WHO's cooperation with countries and support for national and community action in health promotion and protection to prevent disease, injury and disability, the encouragement of healthy lifestyles and behaviour, with particular reference of to tobacco, alcohol and drug dependence, hygiene, sexual practices and violence, and the promotion of family- and community-based interventions to ensure and enhance family well-being.

WHO has periodically evaluated the implementation of the Global Strategy for Health for All, and a second evaluation was published (World Health Organization, 1993d). The role of health legislation in primary health care was emphasized in this second evaluation, and it was noted that many Member States have reviewed their health laws and regulations with a view to supporting health development, reorienting health systems towards the primary health care approach, and controlling substance abuse, all of which were considered important for improving health and achieving the goal of health for all. A third evaluation of progress conducted in 1977, showed significant improvements worldwide both in health status and in access to health care (World Health Organization, 1998b) and identified a "noticeable lack of political commitment to attain health for all in some Member States" citing lack of law enforcement as one factor (World Health Organization, 1997).

Previous WHO studies have also emphasized (Curran, Arif & Jayasuriya, 1987) that, together with the medical profession, the community itself has an equally important part to play, and that the health system should educate and motivate people to assume responsibility for their own health. In this regard, the "open community" and related community-participation programmes are reviewed in this chapter.

## 4.2 Primary care and community integration

### 4.2.1 *Community participation*<sup>1</sup>

Alcohol and drug abuse problems have been on the increase in developing countries in recent decades due to several factors such as lack of information on the short- and long-term consequences of excessive use of alcohol and drugs, increased and easy availability of the substances, limited law-enforcement measures, a general lack of awareness of the real dimensions of the problems at both national and community levels, escalating socioeconomic difficulties, and ineffective or inappropriate interventions. The most promising efforts in the developing countries have been associated with integrating drug and alcohol treatment and rehabilitation into primary health care. Improvements have been achieved, it is suggested, through the training of primary health care and community workers in the detection and management of alcohol and drug problems using simple and practical technologies suggested by WHO. Despite these and other advances in more effective methods of managing drug and alcohol problems at primary health care and other levels, there is still a great need for a clear definition of roles at the different levels of the health care system.

In some developed countries, national legislation and policy is adopted to strengthen community involvement. For example, in the United States, an Act (Public Law No. 105-28) of 27 June 1997, to amend the National Narcotic Leadership Act of 1988, establishes a programme to support and encourage local communities that first demonstrate a comprehensive long term commitment to reduce substance abuse among youth (IDHL, 1999, 50[1]).

### 4.2.2 *Policies and legislation providing for the development of primary health care services*

We examined legislation providing for treatment services in the community, linked to primary care or general health services. In addition, we asked country-level contacts to describe provisions in regulations (or ministerial orders) providing for the development of primary health care services (e.g. involvement of primary health care practitioners; links between mental hospitals and the community; and involvement of traditional healers). No clear general trend towards integration into community services was identified. Some of the different policy, legislative and programmatic approaches (covering, primary care, mental health services, general health services, and community centres) found in some of the survey countries are noted below.

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<sup>1</sup> Participants at the Harvard Advisory Group meeting addressed community participation in various countries. What follows (4.2.1) is based on a paper presented at the meeting by Dr S.W. Acuda (S.W. Acuda, unpublished observations, 1994).

In Belgium, the Order of 12 October 1988 of the Flemish Executive on the authorization of mental health services and on the granting of subsidies to such services, applies to mental health centres, defined as extramural facilities which, through a multidisciplinary approach to mental health and particularly through cooperation with other auxiliaries, dispenses integrated therapeutic care to the patient within the customary context of his life and family and working environment, while also developing preventive activities. These centres are responsible for the following tasks:

- providing care and psychological support of a general nature;
- organizing or providing special care to specific age groups, such as children, adolescents, and elderly persons, or to target groups, such as drug-dependent persons, deprived persons, and migrants; and
- cooperating in preventive activities.

In Egypt, it is reported (A. Alkott, personal communication, 1994) that no specific regulatory provisions applicable to primary health care practitioners exist, but in general physicians are the only persons authorized to prescribe drugs. Certain drugs considered to be of an addictive nature are listed in tables attached to the anti-narcotic law No. 122 of 1989, concerning the control of narcotic drugs and regulation of their utilization and trade in them, and the prescribing of such drugs is subject to certain regulations. No definite role is assigned to traditional healers, and no referral system has so far been established for mental hospitals and other health facilities or the community.

In France, a series of decrees, circulars and orders establishes rules on specialized centres and family reception networks for the care of drug-dependent persons, and for families acting as hosts for such persons.<sup>2</sup> These provisions are more fully described in the Chapter 9 section covering regulations of treatment methods and the legislative basis of the following legislation:

- Decree No. 92-590 of 29 June 1992 on specialized centres for the care of drug-dependent persons (see section A2.3);
- Circular D.G.S./2D No. 56 of 6 October 1992 concerning Decree No. 92-590 of 29 June 1992 on specialized centres for the care of drug-dependent persons;
- Order of 18 August 1993 on family reception networks for drug-dependent persons run by officially recognized specialized centres for the care of drug-dependent persons;
- Circular D.G.S./1555/2 D of 4 December 1987 on families acting as hosts for drug-dependent persons.

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<sup>2</sup> The latest mentioned in the present survey is Decree No. 98-1229 of 29 December 1998 on the Centres referred to in Article 355-1-1 of the Public Health Code, requiring outpatient centres for the treatment of alcohol-dependence to meet prescribed staffing (e.g. physicians in charge of multi-disciplinary medico-socio team).



Family reception networks will form an integral part of the specialized system of care for drug-dependent persons. The purpose of the aforementioned Circular D.G.S./1555/2D, of 4 December 1987, which is addressed by the Minister of Social Affairs and Employment to regional and departmental directorates of health and social affairs, is to clarify the characteristics, objectives and operating procedures of the network of host families which, in conjunction with other facilities, is intended to play a significant part in the management of drug-dependent persons. The Circular covers the following subjects: administration; therapeutic objectives; opening and operation; funding; minors; seropositivity for HIV; and training. It stipulates that there must be no systematic screening for HIV seropositivity before the referral of a person to a host family since testing for HIV is at the discretion of the drug-dependent person, and the screening of all placements may not be required as a precondition to entry into the host family. Moreover, the host family may not be informed of HIV-positive status other than by the drug-dependent person.

In Greece, Decision No. A2b/ik.3981 of 7 October 1987 on counselling, support and treatment programmes implements Sections 12, 13, and 14 of Law No. 1729 of 3 August 1987 (see Annex A2.1) and provides for counselling and support programmes for persons abusing narcotics but who are not dependent on them. The programmes are to be provided by psychotherapy units within the framework of the counselling agencies of the Ministry of Health, Social Welfare and Social Security. They will include individual and group therapy and therapy in a family setting, on an outpatient basis, and a programme of treatment, recovery, and social reintegration for persons abusing narcotics and dependent on them.

In Italy (Marches), Regional Law No. 30 of 6 August 1982 prescribing provisions for the prevention, treatment and rehabilitation of drug dependence and other forms of intoxication requires the health services of the local health units to provide the following:

- prophylaxis of pathological conditions connected with the habitual use of psychotropic substances and narcotics;
- basic health treatment;
- substitution drug therapy in accordance with the regulations in force;
- laboratory analyses and "clinical instrument" examinations;
- health information and education, particularly through the basic services, pharmaceutical facilities, and specialized outpatient facilities, as well as information for physicians, pharmacists, outpatient specialists, and basic health and welfare workers;
- psychotherapy;
- psychological support of the families of drug-dependent persons;
- rehabilitation and support of drug-dependent persons assigned to treatment groups;
- intensive care in emergencies;

- inpatient treatment;
- inpatient treatment for purposes of more complex examinations or intensive detoxification treatment;
- appropriate care of drug- and alcohol-dependent pregnant women;
- collaboration with penal institutions (with particular regard to detained minors) and the communal institutions (including barracks); and
- collection and compilation of statistical and epidemiological data.

Section 5 of the Law requires the local health services to draw up annual prevention, treatment, and rehabilitation programmes. Under provisions of Section 6 of the law, the Regional Administration is required to promote and organize; (i) the collection of statistical data; (ii) meetings to discuss and assess action; (iii) the dissemination of information on the problems concerned; and (iv) investigations to determine the overall situation. In addition, Section 7 requires the Regional Administration to convene periodically, and in any case not less than once a year, a conference of local health and welfare workers and the staff of public and private institutions (including voluntary organizations engaging in drug-dependence control), in order to evaluate the action carried out under the Law and to improve knowledge of: the pharmacological and chemical characteristics and the psychological, physical and social effects of psychotropic substances, including those that are commonly used and widely distributed, such as alcohol, tobacco, and cannabis and its derivatives; the most appropriate methods for the diagnosis of drug dependence; and the most effective methods of carrying out detoxification treatment.

In Mexico, it was reported (M.E. Medina-Mora, personal communication, 1994) that the concept of health has evolved from an emphasis on the curative aspects of medical care to public health and finally to "integral health" that includes the characteristics of the individual, the effects of the environment, individual and social behaviour and the social response through the organization and operation of services. Many modifications in the structure of the Ministry of Health, in education curricula, in research investment, in the programmes for the provision of services, and a major effort to develop a complete vaccination programme for the entire Mexican population, as well as a major decrease in infant mortality through campaigns to educate the population, to prevent and provide early and adequate care for cases of diarrhoea, are examples of this new conception. Prevention and early identification of alcohol and drug dependence are part of the National Programme Against Addictions and there are technical standards (Technical Standard 197 on alcohol and Technical Standard 198 on drugs) for the execution of these programmes.

In Hungary, it is reported (K. Szomor, personal communication, 1999) that since the beginning years of the 1990 decade, local governments have established and operated health and social care institutions, including for drug dependent persons. Drug treatment costs are covered by the National Health Insurance Fund; rehabilitation costs covered in part by the National Health Insurance Fund.

In India, it is reported (M. Suresh Kumar, personal communication, 1994) that emphasis is placed on the need to integrate drug- and alcohol-treatment services into general health care delivery. Moreover, services for those with mental health problems are being moved from mental hospitals to the community under the provisions of the National Community Mental Health Programme. Primary care workers are given training on mental health and drug services. It is also reported that no serious attempt has been made to include traditional healers in such training.

In Ireland, it is reported (M. Lyons, personal communication, 1994) that there are no statutory provisions in this area but that the policy is to increase the involvement of primary care doctors in treating, caring for and managing patients in the community and in community-based services and units. Integration of institutional and primary/community care services is an integral component of health care in Ireland.

In Kazakhstan, it is reported (B. Ajdeldjaev, personal communication, 1994) that, for purposes of prevention and in order to locate patients suffering from drug dependence, treatment centres cooperate with the general medical network and public organizations.

In Madagascar, (C. Ralambo, personal communication, 1994), the treatment and management of drug addicts are still the responsibility of the specialist centres, no part is played by the primary health care centres, and there is no contact with traditional healers.

In the Netherlands, it is noted (Jellinek Centre, unpublished observations, 1994) that general practitioners do not participate officially in the care of drug-dependent persons on a substantial scale, but that some play an officially recognized part in supplying methadone as harm-reduction medication in Amsterdam, that general hospitals play hardly any role in care of such persons, and that detoxification is rarely performed in general hospitals. There are however, specialized detoxification departments within the addiction inpatient facilities.

In Pakistan, it is reported (M.H. Mubbashar, personal communication, 1994) that the National Mental Health Programme specifies a community-based primary health care approach in which primary health care physicians are responsible for the treatment of drug-dependants, referral and the maintenance of records, while multipurpose health workers can provide first aid in emergencies and follow up patients in addition to providing support and guidance to "community health guides". These are voluntary workers trained to identify and refer patients, thus acting as a link between health care facilities and the community. The psychiatric units of district hospitals and teaching hospitals are responsible for training and the provision of referral services. It is further reported that occupational therapy and rehabilitation units have been provided at some of these facilities; however, there are no regulations governing the day-to-day operations of these treatment and rehabilitation facilities.

In Poland, it is reported (J. Morawski, personal communication, 1994), that, pursuant to the Ordinance of 3 August 1985, the Minister of Health and Social Welfare requires primary health care services to participate in drug-abuse prevention. As a patient's first point of contact with the health care system, such services perform preventive functions, provide initial treatment, and refer patients to specialized centres. Primary health care centres at the place of residence, workplace, or at universities are required to participate in the treatment and rehabilitation of alcohol-dependent persons.

In the United States of America, it is reported (D. Des Jarlais, personal communication, 1994) that, in general, drug-abuse treatment is quite separate from primary medical care, although there have been some attempts at integration in the last few years.

In Zimbabwe, drug and alcohol treatment and rehabilitation are combined and the primary health care concept has been adopted (S.W. Acuda, personal communication, 1994). Also in Zimbabwe, several resource centres reportedly (A. Chidarikire, personal communication, 1994) routinely refer alcohol and drug abusers in accordance with the Mental Health Act, 1976 (Section 34) and implementing regulations. Psychiatrists, psychologists and social workers refer their patients for counselling and rehabilitation by other sectors when appropriate. Experience shows that there appears to be effective coordination, facilitated by the existing legislation.

#### 4.2.3 *Open-community approach*

The "open community approach", a community-based approach to the treatment and care of both drug- and alcohol-dependent persons was the subject of a 1993 WHO Consultation (World Health Organization, 1993e).

The Consultation was part of the effort by WHO to develop low-cost, effective treatment services for persons affected by the harmful and dependent use of psychoactive substances and for reducing the complications and sequelae (e.g. HIV infection and AIDS) linked to the use of such substances<sup>3</sup>. The "open-community approach" is most appropriate for the large-scale treatment and care of dependent persons in areas with high rates of drug use, and particularly in villages and townships where traditions are highly valued. It is best suited to developing countries with scarce resources and a high prevalence of drug-related problems. Some components or features that characterize the approach identified in the Consultation are mass detoxification; homogeneous groups; medication and treatment; back-up medical support; the involvement of persons no longer dependent on drugs; celebration and

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<sup>3</sup> The 1993 WHO Consultation resulted in several unpublished papers on the subject e.g. See Bui Duc Trinh (1993) Community-Based Approach to the Treatment and Care of Drug Addicts in Bac Thai, Viet Nam, Dr Bui Duc Trinh, Department of Psychiatry, Bac Thai College of Medicine, Thai Nguyen City, Viet Nam (available on request from WHO/PSA).

optimism; spirituality; family involvement; community support (e.g. provision of food); support persons such as friends or relatives; problem solving; and community strengthening. Law-enforcement officials should be encouraged to participate in community-treatment programmes, by diverting drug- or alcohol-dependent persons into such programmes, in lieu of arrest or prosecution.

Properly structured methadone maintenance programmes can also be considered for incorporation into the open-community approach if they provide rehabilitation either without or before detoxification.

### **4.3 Employee assistance in the workplace<sup>10</sup>**

In Egypt, there are serious problems of drug abuse of several substances including amphetamines and cannabis □ as well as alcohol abuse. The stigmatization of drug-dependent persons is stronger in workplace settings than in any other place, they are seen as problem-makers and non-productive persons, and superiors prefer to terminate their employment or suspend them rather than refer them to treatment.

Nevertheless, workplace initiatives have been introduced among 25 large companies, but are resisted by some management staff who refuse to rehire rehabilitated former employees because of fears of relapse. Supervisors and workers are reluctant to report or help in case-finding or in the follow-up process because most believe it is unethical to do so or provide information that might deprive drug-dependent workers of their jobs and source of livelihood. Urinalysis, a reliable way of monitoring and detecting relapse, is difficult in the workplace. Some police officers insist on being informed of positive test results. In some Arab countries, problems of alcohol and drug abuse and dependence are often officially denied or down-played, which adds to the difficulty of intervention. Most legislation in the Eastern Mediterranean Region is in need of revision so as to support rehabilitation and resocialization.

### **4.4 Self-help and mutual support organizations**

#### **4.4.1 General**

Autonomous self-help or mutual-support organizations provide treatment, after-care, rehabilitation and resocialization for drug- and alcohol-dependent persons in a variety of arrangements and settings. For example, in some of the prison centres in Bolivia, it is reported (A. Alem Rojo, personal communication, 1994) that self-help

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<sup>10</sup> Participants at the Harvard Advisory Group meeting addressed the subject of employee assistance in the workplace. What follows (4.3) states the main elements of a paper presented at the meeting by Dr Alsayed Alkott (A. Alkott, unpublished observations, 1994).

groups and therapeutic communities exist for both alcohol- and drug-dependent persons, and that prisoners seek support from institutions in the community. Similarly, in Poland it is reported (E. Grudziak Sobczyk, personal communication, 1994) that new programmes for alcohol-dependent prisoners have been started, resulting in more effective resocialization, in part due to the cooperation of self-help groups and Alcoholics Anonymous. In Bahrain, it is reported (M.K. Al-Haddad, personal communication, 1993) that the frequency of Narcotics Anonymous meetings has increased from once to twice a week; and that a close liaison has developed between hospital staff and self-help groups such as Alcoholics Anonymous. In Poland it is reported (J. Morawski, personal communication, 1994) that, in practice, after-care, rehabilitation and resocialization are provided mainly by nongovernmental organizations, e.g. clubs of abstainers and Alcoholics Anonymous.

#### 4.4.2 *Self-help in Hong Kong*<sup>11</sup>

While bodies like Alcoholics Anonymous and Narcotics Anonymous function effectively in various parts of the world, there is a need to adapt them to the conditions existing in Asia and in other developing countries. It is also recognized, that self-help groups can play many roles, help in community education, and assist in programmes on case-finding, peer counselling, role modelling, and after-care re-entry into society. Professional health workers should be encouraged to ally themselves with self-help organizations so as to turn former service recipients into service providers. Thus in Hong Kong, self-help "networking" as part of after-care is encouraged by most of the treatment programmes. The oldest self-help organization is the Former Alumni Association of the Society for the Aid and Rehabilitation of Drug Abusers (SARDA), which was established by a small group of after-care clients in 1967. It was subsequently incorporated as the Pui Hong Self-Help Association and reported to have a membership of 1900 drug-free men and women, of whom some 500 were active in organizing preventive education programmes for the public. In April 1990, the Association took over from SARDA the operation of the Employment Guidance and Loan Fund Scheme and the Cleansing Service Cooperative sponsored by the Lok Sin Tong Benevolent Society. These assist persons recently discharged from SARDA treatment facilities by providing temporary employment and living allowances until regular employment in the open market is obtained. The Association's out-reach teams have, since 1991, conducted annual street addicts surveys on AIDS awareness, saliva screening and harm-reduction counselling.

In addition, the Caritas Lok Heep Club provides social networking facilities for drug-dependent persons participating in methadone maintenance programmes or

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<sup>11</sup> Participants at the Harvard Advisory Group meeting addressed the subject of self-help organizations. What follows (4.4.2) states the main elements of a paper presented at the meeting on self-help organizations in Hong Kong by Dr James M.N. Chi'en (J.M.N. Chi'en, unpublished observations, 1994), where the important role that such organizations can play in the field of drug and alcohol treatment and rehabilitation is recognized and supported.

under the compulsory supervision of the Hong Kong Correctional Services (See section A2.2) for a summary of the discharge procedure provisions of the Drug Addiction Treatment Centers Ordinance, which provide that the Commissioner of Correctional Services may order medical examinations and residence requirements for a period of 12 months from the date of release).





## **5. International conventions, national implementation and United Nations guidelines**

### **5.1 International conventions**

The Single Convention on Narcotic Substances 1961, as amended by the 1972 protocol, (hereinafter, "the 1961 Single Convention"), the Convention on Psychotropic Substances (adopted in 1971), and the United Nations Convention Against Illicit Traffic In Narcotic Drugs and Psychotropic Substances (adopted in 1988) (hereinafter "the 1988 Convention") are the major international drug-control treaties currently in force.

As requested by the United Nations International Drug Control Programme in its *Monthly Status of Treaty Adherence*, (United Nations, 1999b) as of 4 October 1999, 168 States were parties to the Single Convention on Narcotic Drugs 1961, or to that Convention as amended by the 1972 Protocol; 159 were parties to the Convention on Psychotropic Substances; and 153 were parties to the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (United Nations, 1999b).

The 1961 Single Convention outlawed the production, manufacture, trade and use of narcotic substances for non-medical purposes, limited the possession of all such substances to those using them for medical and scientific purposes and to persons authorized to possess them. It also provided for the international control by government agencies of all transactions involving opium by authorizing opium production only by licensed farmers in areas and on plots designated by these agencies.

Article 38 (as amended by the 1972 Protocol) of the 1961 Single Convention contains the following provisions relating to the treatment of drug-dependent persons:

- The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.
- The Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation and social reintegration of abusers of drugs.
- The Parties shall take all practicable measures to assist persons whose work so requires to gain an understanding of the problems of abuse of drugs and of its prevention, and shall also

promote such understanding among the general public if there is a risk that abuse of drugs will become widespread.

An official commentary on the 1972 Protocol amending the 1961 Single Convention (as amended) (United Nations, 1976a)<sup>12</sup> analyses the provisions on the approach to treatment. The four terms "treatment", "after-care", "rehabilitation" and "social reintegration" were used in order to indicate that the Parties should take all "practicable measures" that may be required.

The provisions relating to treatment in the Convention on Psychotropic Substances are contained in Article 20, and read as follows:

- The Parties shall take all practicable measures for the prevention of abuse of psychoactive substances and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.
- The Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation, and social reintegration of abusers of psychotropic substances.
- The Parties shall assist persons whose work so requires to gain an understanding of the problems of abuse of psychotropic substances and of its prevention, and shall also promote such understanding among the general public if there is a risk that abuse of such substances will become widespread.

A commentary on the Convention on Psychotropic Substances notes that the above wording follows very closely that of Article 38 of the 1961 Single Convention (United Nations, 1976a). It is recognized that a system of administrative controls and penal sanctions aimed at keeping narcotic drugs from actual and potential victims is the essence of the 1961 Single Convention, as amended in 1972, and this system is extended to cover psychotropic substances in the Convention on Psychotropic Substances. However, administrative and criminal sanctions should not form the sole subject of international cooperation against drug abuse, and a multidisciplinary approach is required. The term "practicable" is defined to mean what can reasonably be expected of a Member State in the light of its resources and the extent of the problem of psychotropic substance abuse.

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<sup>12</sup> The United Nations has also published a Commentary on the Single Convention on Narcotic Drugs, 1961 (United Nations, 1973).

The commentary also notes that treatment, after-care, rehabilitation and social reintegration are considered as the four stages necessary to restore the well-being and social usefulness of abusers of both narcotic drugs and psychotropic substances.

The commentaries on both Conventions emphasize, however, that agreement on the exact dividing lines between the four stages is not necessary to appropriately implement the provisions of the relevant Article. The four terms were used to indicate that Member States should comprehensively apply "all practicable measures" that may be useful.

Article 36 of the 1961 Single Convention, as amended, contains criminal law provisions, including diversion to treatment for persons who have committed punishable offences under the terms of the Convention:

- Subject to its constitutional limitations, each Party shall adopt such measures as will ensure that cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provision of this Convention, and any other actions which in the opinion of such Party may be contrary to the provisions of this Convention, shall be punishable offenses when committed intentionally, and that serious offenses shall be liable to adequate punishment particularly by imprisonment or other penalties of deprivation of liberty.
- Notwithstanding the preceding paragraph, when abusers of drugs have committed such offenses, the Parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment, education, after-care, rehabilitation, and social reintegration in conformity with paragraph 1 of article 38.

Article 22 of the Convention on Psychotropic Substances also contains criminal law provisions, including diversion to treatment for certain persons, as follows:

- Subject to its constitutional limitations, each Party shall treat as a punishable offence, when committed intentionally, any action contrary to a law or regulation adopted in pursuance of its obligations under this Convention, and shall ensure that serious offenses shall be liable to adequate punishment, particularly by imprisonment or other penalty of deprivation of liberty.

- Notwithstanding the preceding subparagraph, when abusers of psychotropic substances have committed such offenses, the Parties may provide, either as an alternative to conviction or punishment or in addition to punishment, that such abusers shall undergo measures of treatment, education, after-care, rehabilitation, and social reintegration in conformity with paragraph 1 of article 20.

Adoption of the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, was the most significant development in international drug control conventions since the adoption, in 1971, of the Convention on Psychotropic Substances. One provision of the 1988 Convention of significant importance for treatment and rehabilitation is the requirement (Article 14) that Member States should adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, and that these measures may be based on the recommendations of specialized agencies of the United Nations, such as WHO.

In countries with newly emerging political and legislative systems, or where there is little prior law, the conventions have stimulated legislative development. Thus the 1988 Convention requires signatories to make the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption a criminal offence under domestic law, and this has had a significant impact in some countries.

While the 1988 Convention was intended to be concerned solely with illicit traffic, it also contains important demand-reduction provisions. It recognizes the links between illicit traffic and other related organized criminal activities that undermine society, and strives to eliminate the root causes of narcotic and psychotropic substance abuse, including illicit demand for these drugs. In order to "counter the magnitude and extent of illicit traffic and its grave consequences", the Convention reaffirms the guiding principles of the existing treaties, but recognizes a need to reinforce and supplement the measures provided for in both the 1961 Single Convention, as amended, and the Convention on Psychotropic Substances.

The aim was therefore the adoption of a comprehensive and effective convention directed specifically against illicit traffic and covering, in particular, those aspects of the problem not covered by the two earlier conventions. The purpose of the 1988 Convention is therefore to promote cooperation among signatory countries in dealing more effectively with the various aspects of the international illicit traffic in narcotic drugs and psychotropic substances. Signatory countries are required to enact legislative and administrative provisions and take other necessary measures to carry out their obligations under it in conformity with signatory country domestic law.

Article 3, paragraph 1, establishes offenses and sanctions:

- Each Party shall adopt such measures as may be necessary to establish as criminal offenses under its domestic law, when committed intentionally [these are enumerated].

Article 3, paragraph 2, covers possession and other acts related to personal consumption:

- Subject to its constitutional principles and the basic concepts of its legal system, each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, as amended, or the 1971 Convention.

Article 3, paragraph 4, sets out the provisions for governing treatment and other measures:

- Each Party shall make the commission of the offenses established in accordance with paragraph 1 of this article liable to sanctions which take into account the grave nature of these offenses, such as imprisonment or other forms of deprivation of liberty, pecuniary sanctions and confiscation.
- The Parties may provide, in addition to conviction or punishment, for an offence established in accordance with paragraph 1 of this article, that the offender shall undergo measures such as treatment, education, after-care, rehabilitation or social reintegration.
- Notwithstanding the preceding subparagraphs, in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment, measures such as education, rehabilitation or social reintegration, as well as, when the offender is a drug abuser, treatment and after-care.
- The Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offence established in accordance with paragraph 2 of this article, measures for the treatment, education, after-care, rehabilitation or social reintegration of the offender.

Article 14 of the 1988 Convention states measures aimed at eradicating the illicit cultivation of narcotic plants and eliminating illicit demand for narcotic drugs and psychotropic substances:

- The Parties shall adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic. These measures may be based, inter alia, on the recommendations of the United Nations, specialized agencies of the United Nations such as the World Health Organization, and other competent international organizations, and on the Comprehensive Multidisciplinary Outline adopted by the International Conference on Drug Abuse and Illicit Trafficking, held in 1987, as it pertains to governmental and non-governmental agencies and private efforts in the fields of prevention, treatment and rehabilitation. The Parties may enter into bilateral or multilateral agreements or arrangements aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances.

There are no analogous international conventions on alcohol.

## **5.2 Impact on development of national legislation**

The international conventions have had a somewhat mixed impact on the development and implementation of national policies and legislation authorizing the treatment and rehabilitation for drug-dependent persons in both the civil and criminal justice systems.

Overall, the conventions have had a variety of reported positive outcomes leading to the development of new drug-control legislation or the repeal of existing legislation, or to the modification of existing laws on treatment and rehabilitation. Thus in Austria (I. Erlacher, personal communication, 1994) they led to an amendment to the Narcotic Drugs Act, 1980 which emphasized the principle "treatment instead of punishment". In Canada, the Controlled Drugs and Substances Act, assented 20 June 1996 consolidated Canada's drug control policy to fulfill obligations under the 1961 Single Convention, the Convention on Psychotropic Substances, and the relevant parts of the 1988 Convention.

In Finland, the conventions had reported a stabilizing and an overall preventive effect (J. Eskola, personal communication, 1994) providing a basis for preventive policies. In Egypt, they provided international expertise and a framework which facilitated the national development of policies and programmes (A. Alkott, personal communication, 1994).

In some countries, the conventions have led to rapid legislative development following ratification, e.g. the Latvian Parliament ratified the conventions (1961 Single Convention, Convention on Psychotropic Substances, and the 1988 Convention) on 11 May 1993; this facilitated the development of national drug-control policies, promoted the establishment of a national dangerous drug board, and influenced the development of interministerial programme activities (J. Strazdins, personal communication, 1994). In Lithuania, on 27 January 1994, Lithuania ratified the 1961 Single Convention and the Convention on Psychotropic Substances. On 12 March 1998, Lithuania ratified the 1988 Convention (Lithuania, 1999).

The international conventions and other international documents are considered very important in the Philippines drug field.<sup>13</sup> In the past, the drug laws in the Philippines were focused exclusively on illicit drugs and were highly punitive in character. Following the Convention on Psychotropic Substances, however, many improvements were made: i.e. a Dangerous Drug Board now exists and, in addition to continuing law-enforcement efforts, education, treatment and research are carried out. A gap still exists, however, in respect of alcohol-dependence, since the Philippines lacks both laws and programmes in this field. A significant poly-drug abuse problem, including alcohol abuse, exists in the Philippines. Thus here, too, an international approach is needed to stimulate the development of new programmes on alcohol abuse.<sup>14</sup>

Others in Australia (I. Webster, personal communication, 1994) believe that the conventions prevent the development of a national orientation based on harm-minimization principles.

Several national governments in the European Region have enacted national legislation implementing treaties in formal recognition of national political unification. An example is the Law of 23 September 1990 on the Treaty of 31 August 1990 between the Federal Republic of Germany and the German Democratic Republic on the establishment of German unity "the Unification Treaty Law" and the Agreement of 18 September 1990. The Law specifies that it is the function of the legislature to create conditions such that the level of inpatient care of the population in the five new *Länder* improves and reaches that in the rest of the territory of the Federal Republic.

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<sup>13</sup> Participants at the Harvard Advisory Group meeting addressed international standards and national statutory provisions for drug- and alcohol-treatment and rehabilitation. This paragraph states the main elements of the paper presented at the meeting by Attorney Manuel Supnet (M. Supnet, unpublished observations, 1994).

<sup>14</sup> Progress has been made at the regional level. A WHO meeting, held in Paris, on 12-14 December 1995, adopted the European Charter on Alcohol.

### **5.3 United Nations declarations**

Significant United Nations declarations and other instruments on drug control in which treatment is covered have been published since the 1986 WHO survey (Porter, Arif & Curran, 1986).

#### **5.3.1 *Political Declaration***

From 8-10 June 1998, at its 20th Special Session devoted to the world drug problem, the United Nations General Assembly focused on six areas in its declaration on drugs: (1) demand reduction; (2) elimination of illicit crops and alternative development; (3) money laundering; (4) amphetamine-type stimulants; (5) judicial cooperation; and (6) precursor chemicals. The General Assembly affirmed its determination to provide all necessary resources for treatment and rehabilitation and to enable social reintegration to restore dignity and hope to children, youth, women and men who are drug abusers (United Nations, 1998a).

#### **5.3.2 *Declaration of the Guiding Principles of Drug Demand Reduction***

The guiding principles of drug demand reduction concerning treatment and rehabilitation include: providing -- either as an alternative to conviction or punishment or in addition to punishment -- that drug abusers should undergo treatment, education, aftercare, rehabilitation, and social reintegration; and that Member States should develop within the criminal justice system, where appropriate, capacities for assisting drug abusers with education, treatment and rehabilitation services. In this context, close cooperation between criminal justice, health and social system is a necessity and should be encouraged, the Declaration states (United Nations, 1998b).

#### **5.3.3 *Declaration of the International Conference on Drug Abuse and Illicit Trafficking, and Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control***

The first is the Declaration of the International Conference on Drug Abuse and Illicit Trafficking, and Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control, adopted in 1987 by the International Conference on Drug Abuse and Illicit Trafficking and published in 1988 (United Nations, 1988). This Declaration is significant because of its emphasis on treatment and rehabilitation, e.g. in the preface:

The International Conference on Drug Abuse and Illicit Trafficking was convened at Vienna from 17 to 26 June 1987 as an expression of the political will of nations to combat the drug menace on a world wide basis. The General Assembly, in its resolution 40/122 of



13 December 1985, gave the Conference a mandate "to generate universal action to combat the drug problem in all its forms at the national, regional and international levels". Transcending the traditional concerns of the international community with the control of the supply of narcotic drugs and psychotropic substances and of the illicit traffic in drugs, the Conference made a major breakthrough by deciding that a balanced approach was needed to deal with this plague affecting society and that the prevention of drug abuse and treatment and the rehabilitation of drug abusers should be accorded the same importance in policy and in action as the reduction of supply and illicit traffic.

The companion Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control (United Nations, 1988) was also adopted also by the Conference and is a compendium of practical action for governments, the United Nations system, intergovernmental and regional organizations, nongovernmental organizations, academic institutions and individuals to take in combatting drug abuse and illicit trafficking. It has 35 action targets in four chapters, which the 1987 Vienna Conference believed could be reached within 10-15 years.

The seven targets contained in the chapter on treatment and rehabilitation are as follows:

1. Towards a policy of treatment.
2. Inventory of available modalities and techniques of treatment and rehabilitation.
3. Selection of appropriate treatment programmes.
4. Training for personnel working with drug addicts.
5. Reduction of the incidence of diseases and the number of infections transmitted through drug-using habits.
6. Care for drug-addicted offenders within the criminal justice and prison system.
7. Social integration of persons who have undergone programmes for treatment and rehabilitation.

Four of the suggested courses of action at the international level under the target "towards a policy of treatment" are relevant for our purposes:

344. WHO should indicate the principal factors to be taken into account in the formulation of a policy for the treatment of drug addiction.

346. Member States should involve WHO in establishing or strengthening national policy for the treatment of drug addiction.

347 WHO should be urged to prepare, in cooperation with international and governmental organizations, a plan for disseminating knowledge about the way in which national treatment policies can be established and strengthened.

348 The work of WHO on nosology should be encouraged and expanded, and governments should assist WHO in field testing the validity of the nosology in various locations.<sup>15</sup>

Target 34 (of the comprehensive multidisciplinary outline) concerns care for drug-addicted offenders in the criminal justice and prison system. Suggested courses of action for WHO include:

404. The appropriate authority might direct .... that the necessary medical, educational, and support care should be provided for drug addicts held in custody pending trial and for convicted drug abusers.

407. WHO and the United Nations Social Defence Research Institute might consider preparing guidelines for the treatment of drug offenders who are drug addicts.

#### 5.3.4 *Political Declaration and Global Programme of Action for international cooperation in the control of drug abuse and illicit trafficking in narcotic drugs and psychotropic substances*

Another United Nations instrument is the Political Declaration and Global Programme of Action for international cooperation in the control of drug abuse and illicit trafficking in narcotic drugs and psychotropic substances, adopted at the seventeenth special session of the General Assembly, pursuant to resolution S-17/2 of 23 February 1990 (United Nations, 1990a). The General Assembly requested that:

- States should take the necessary measures to promote and implement the Global Programme of Action and to translate it into practical action to the widest possible extent at the national, regional and international levels. The United Nations and its

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<sup>15</sup> WHO has published (World Health Organization, 1994b) a lexicon of alcohol and drug terms with the aim of providing a set of definitions of terms relating to alcohol, tobacco, and other drugs, for use by clinicians, administrators, researchers, and other interested persons. Explanatory definitions, often including psychoactive effects, symptomatology, sequelae, and therapeutic indications, are given for each general class of psychoactive drugs and for some related classes. The main diagnostic categories are defined, as are key concepts in scientific and/or popular use. Both the social and the health aspects of drug use and problems related to such use are covered.

relevant bodies and specialized agencies, other relevant intergovernmental organizations and non-governmental organizations should extend their cooperation and assistance to States in the promotion and implementation of the Global Programme of Action (paragraph 96).

- States and the United Nations, in United Nations' regional coordination, shall provide advice and legal technical assistance to enable States, at their request, to adapt their national legislation to international conventions and decisions dealing with drug abuse and illicit trafficking (paragraph 75).
- National strategies in the health, social, legal and penal fields shall contain programmes for the social reintegration, rehabilitation and treatment of drug abuses and drug addicted offenders (paragraph 30).
- Training programmes relating to the latest developments and techniques in the field of treatment of drug addiction and rehabilitation and reintegration of former addicts must be conducted more regularly at the national, regional and international levels (paragraph 33).
- The United Nations shall act as a clearinghouse for information on effective policies and techniques, programme modalities and resource materials for the treatment, rehabilitation and occupational reintegration of former drug addicts. The World Health Organization and the International Labour Organisation, in collaboration with other organizations of the United Nations system and non-governmental organizations, shall be encouraged to contribute to that end (paragraph 31).
- The World Health Organization shall be encouraged to work with Governments with a view to facilitating access to drug treatment programmes and to strengthening the capacity of primary health care to respond to drug related health problems (paragraph 34).

### 5.3.5 *Integration*

The United Nations instruments reviewed above, together with the three international conventions, provide the necessary guidance for national and international organizations in developing treatment and rehabilitation policies and legislation. Consideration should be given, however, to the way in which the principles and concepts of harm reduction can be effectively integrated with these instruments and conventions.



## **6. Regional agreements and bilateral collaboration**

### **6.1 Regional agreements**

Collaborative agreements among countries have been reached in various geographical regions on dealing with the problems of drug and alcohol abuse and their control.

#### **6.1.1 *Organization of African Unity/African Economic Community***

As noted in the previous WHO study (Porter, Arif & Curran, 1986), the current survey reveals that the various regional grouping are of widely different types, some being both geographical and economic in character, such as the Organization of African Unity Treaty establishing the African Economic Community, established by the Treaty signed at Abuja, Nigeria, on 3 June 1991. Member States adhering to the Treaty agree to ensure the full participation and rational utilization of their human resources in their development efforts "with a view to eliminating other social scourges plaguing the continent". They agree that, to reach this end, they will harmonize their efforts to put an end to the illegal production, trafficking and use of narcotic drugs and psychotropic substances, and formulate sensitization and rehabilitation programmes in this field.

#### **6.1.2 *European Union***

On 1 January 1995, the European Union increased its membership from 12 to 15 countries upon the joining of Austria, Finland and Sweden. The European Union has adopted Council Resolution No. 302/93 of 8 February 1993 (European Union, 1993) on the establishment of a European Monitoring Centre for Drugs and Drug Addiction. The objective of this Resolution is to provide the Community and its Member States with objective, reliable and comparable information at the European level concerning drugs and drug addiction and their consequences. The four broad tasks of the Centre are: (1) the collection and analysis of existing data; (2) the improvement of data -comparison methods; (3) the dissemination of data; and (4) cooperation with European and international bodies and organizations and with non-Community countries. There are six priority areas, of which the first is reduction in the demand for drugs, and the second national and Community strategies and policies, with special emphasis on international, bilateral and Community policies, action plans, legislation, activities and agreements.

Council Regulation (EC) No. 2046/97 of 13 October 1997 on North-South Cooperation in the campaign against drugs and drug addiction states that the community is to give priority at the request of a partner country to supporting the

preparation of a National Drug Control Master Plan; specifically supporting demand reduction operation of treatment for drug addicts.

Also of interest is a Resolution of 16 May 1989 of the Council and the Ministers for Health of the Member States meeting within the Council concerning a European network of health data on drug abuse. Moreover, on 23 June 1994, the Commission of the European Communities submitted a document to the Council and the European Parliament outlining the principal themes of a European Union action plan to combat drugs for the period 1995-1999 (European Union, 1994). In this document, an integrated approach and the general directions of the European Union's actions are suggested, together with activities in the following five main areas: (1) demand reduction; (2) reduction of illicit trafficking in narcotic drugs and psychotropic substances; (3) international action; (4) coordination; and (5) budget. Specific demand-reduction activities should include: (i) encouraging and facilitating activities targeted at high-risk groups in specific settings; (ii) promoting the identification, development, testing and use of best practices for disseminating information and providing advice to target groups; (iii) promoting initiatives in the field of education and training in order to develop drug-prevention strategies; (iv) supporting work on early detection and the counselling of drug users; and (v) promoting the rehabilitation and social reintegration of drug addicts. The Annual Report on the state of the Drug Problem in the European Union (European Union, 1997) published by the European Monitoring Centre for Drugs and Drug Addiction, states national strategies and action taken by the European Union, including alternatives to prosecution and treatment (European Union, 1997).

### 6.1.3 Council of Europe

*Drug dependence.* Council of Europe Recommendation No. R 98 (98) of the Committee of Ministers to Member States concerning dependence was adopted by the Committee of Ministers on 18 September 1998. This Recommendation sets out general principles in respect of dependent persons, e.g. help dependent persons live life according to their needs; prevent or reduce dependence, prevent increases in drug dependence, and alleviate its consequences. Council of Europe Recommendation No. R (82) 6 of the Committee of Ministers to member states concerning the treatment and resocialization of drug dependents was adopted by the Committee of Ministers of the Council of Europe on 16 March 1982 (Council of Europe, 1982). This Recommendation reiterated that the aim of the Council of Europe is to achieve greater unity between its members and that this aim may be pursued by the adoption of a common approach in the health, social welfare and social security fields. It recognized that drug dependence is an important social and health problem in most of the member states; that all drug-dependents, whatever their personality structure or social background, require treatment for resocialization but that it is not realistic to adopt one standard of treatment; that all treatment programmes should provide multifunctional aid and treatment and that, within these programmes, pharmacological methods should be

seen as only part of the programme and should never be applied alone; that at present there is little scientifically based data available on the effectiveness of treatment programmes but that successful treatment of drug-dependents is possible; and that there has been insufficient evaluation of treatment programmes in Europe.

The Council recommended to governments of member states:

*Approach to the problem*

1. that aid and treatment for drug dependents should be integrated as far as possible into the general health and social care system;
2. that where resources are provided for the aid and treatment services for drug dependents, the problem of drug dependence should be seen in relation to health and social problems;

*Facilities and methods*

3. that residential and non-residential facilities (specialized if necessary) should be provided for drug dependents with the opportunity for multifunctional treatment approaches. These facilities should be staffed on a multidisciplinary basis and, where possible, offer treatment of a voluntary nature. They should be linked together within a comprehensive treatment and rehabilitation system (treatment chains);
4. that facilities for case-finding should be provided (e.g. open door centres) where the drug dependant is motivated to seek treatment, but these should be seen only as part of the treatment system;
5. that treatment programmes should include psychotherapeutic and sociotherapeutic methods consistent with the aims and principles of resocialization. Therapeutic methods of this kind should be used in both residential and non-residential facilities;
6. that resocialization should be an integral part of all stages of treatment programmes;
7. that research be undertaken before pharmacological agents are used in the treatment of drug dependence;

*Staff*

8. that such facilities should have qualified staffs with experience in the social, psychological, educational, health and vocational field. Such staffs should receive specialized and continuous training to enable them to carry out their tasks, particular attention being paid to problems resulting from the inclusion of ex-addicts on the staff;

*Evaluation*

9. that evaluation should be introduced into all aid and treatment programmes;
10. that evaluation techniques should be part of training at all levels with particular emphasis on techniques which can be easily handled by the staff;
11. that evaluation to improve programme results should be included as a requirement at all levels;

12. that resources should be provided to improve local need assessment, to establish information systems and to improve outcome evaluation;
13. that the general results of evaluation should be systematically communicated to all concerned, treatment centers, governments, and international organizations involved in treatment programmes;
14. that national authorities, in designing, implementing, managing and evaluating treatment and resocialization programmes for drug dependent persons, make use to the fullest extent possible of the United Nations Resource Book Measures to Reduce the Illicit Demand for Drugs."

*Volatile substance abuse.* The Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group) was formed in 1971, and since 1980 has continued its activities within the framework of the Council of Europe. A seminar, organized by the Pompidou Group on volatile substance abuse, was held in Bratislava in November 1993 (Council of Europe, 1993). The subjects covered during the seminar included: scope of the problem; prevention and education projects; legislation; and treatment. For chronic volatile substance abusers, participants considered that some special treatment (e.g. counselling) was required. Such counselling could be delivered through existing drug treatment facilities. Doubts were expressed concerning the adoption only of a medical approach to treatment, since the young population group involved may require different or additional treatment approaches.

#### 6.1.4 *The Nordic Committee on Narcotic Drugs*

The Nordic Committee on Narcotic Drugs and the Ministry of Social Affairs of Estonia met in Tallinn, Estonia, in May 1993 (Nordic Committee, 1993). The Committee was established in 1970 by the Ministers of Justice of the Nordic countries, and is made up of senior officials concerned with drug-abuse control. It is responsible for developing joint activities to: (1) reduce the supply of drugs; (2) reduce demand for drugs; (3) provide treatment and rehabilitation; and (4) conduct research. The purpose of the May 1993 joint meeting was to discuss the drug situation in the Baltic and Nordic countries, to exchange ideas and experiences regarding drug strategies in the region, to create networks between countries and professional disciplines, and to involve international organizations. The meeting followed the Baltic Cities Expert Meeting on Drug Demand and Supply Reduction, in Turku, Finland, in June 1992, which adopted a resolution containing a number of proposals, of which one was to study the need for developing rules, regulations and agreements governing the drug issue, including legislation concerning sanctions, control and service systems and bilateral and multilateral agreements.



### 6.1.5 *Organization of American States*

The Inter-American Program of Action of Rio De Janeiro Against the Illicit Use and Production of Narcotic Drugs and Psychotropic Substances and Traffic Therein (Organization of American States, 1986) was approved in Rio de Janeiro on 24 April, 1986, at the Inter-American Specialized Conference on Traffic in Narcotic Drugs. The Conference was convened at the direction of the General Assembly of the Organization of American States (OAS). The Program of Action consists of basic principles, objectives and recommendations to OAS Member States and OAS departments, and includes:

- Promotion of programs for the treatment and rehabilitation of drug addicts. Such programs should involve the participation of the Inter-American Specialized Organizations, particularly the Pan American Health Organization (chapter I).
- Carrying out of studies on the harmful effects of the use of inhalants and on mechanisms for controlling their sale, taking into account the necessary social solutions to the problem (chapter I).
- Establishment of central agencies at the national level charged with formulating the respective national plans, policies, and programs regarding narcotic drugs and also with exercising general coordination, supervision, control and monitoring of activities related to drug abuse and unlawful trafficking in narcotic drugs and psychotropic substances (chapter III).
- Encouragement of contacts between the above mentioned central agencies and public and private national, regional, and municipal organizations that are engaged in the prevention of drug abuse and the treatment of drug addicts (chapter III).

## 6.2 **Bilateral agreements**

The Agreement on Cooperation in the Field of Drug Control between Spain and Morocco, dated 21 January 1987, provides for cooperation between the two countries in the form of regular exchanges of information and documentation on prevention, social and health matters; social rehabilitation; and legislation (Spain & Morocco, 1987).

Regional cooperation is planned in a proposed framework agreement on cooperation in drug control between Israel, Egypt, and Jordan. Such an agreement was considered necessary by the parties in the context of the peace process in the region; and the need to ensure that drug problems are taken in account.

As previously mentioned (see related discussion in Chapter 2), China entered into bilateral agreements with the United Kingdom concerning the territory of Hong Kong and with Portugal concerning the Territory of Macao; Section 2.3. The Joint Declaration of the Government of the United Kingdom of Great Britain and Ireland and the Government of the Peoples' Republic of China on the Question of Hong Kong, dated 19 December, 1984, provides that the United Kingdom restore the territory of Hong Kong to China on 1 July 1997 (Hong Kong, 1984). On that date the Basic Law of the Hong Kong Special Administrative Region of the People's Republic of China, dated April 1990 (Hong Kong, 1990) came into effect, and will remain unchanged for 50 years. Under its terms, laws previously in force in Hong Kong, including the common law, rules of equity, ordinances, subordinate legislation and customary law, will be maintained, except for any that contravene the Basic Law, and subject to any amendment by the legislature of the Hong Kong Special Administrative Region. The Joint Declaration of the Government of the People's Republic of China and the Government of the Republic of Portugal on the Question of Macao, and Annexes, dated 13 April, 1987 (Macao, 1987) provides that Portugal restore the territory of Macao to China, on 20 December 1999. On that date, the basic law of Macao Special Administrative Region of China dated 31 March 1993 (Macao, 1999) came into effect, but its economic, social and cultural system will remain unchanged for a period of 50 years (M. Belo, personal communication, 1994). The major administrative affairs the Macao Special Administrative Region conducts include education, public health, science and technology, social welfare, as well as public order (Macao, 1999a). Moreover, the Macao Special Administrative Region courts have jurisdiction and final review authority, over all cases in the Region; except that jurisdictional restrictions previously in force are maintained, and except for foreign affairs and defence (Macao, 1999b).

## 7. Government policy objectives

### 7.1 General

Countries have adopted national policies to control the supply of, and reduce demand for, illicit drugs in fulfilling their obligations under the three international conventions, such policies including the provision of treatment and rehabilitation programmes. There is a tendency for such policies to be published in the form of national strategic planning documents.

Policies are often the product of national-level interministerial commissions or advisory bodies established either by the legislature or by the executive branch. In countries with federal jurisdictions, policies to control supply and reduce demand are often also developed at the subnational (e.g. state, provincial) level. National commissions are often also established in the executive branch of government for the purpose of coordinating the implementation of national or subnational policies.

Primary goals of national policies in different countries, as stated in the national strategic planning documents, include:

- establishing, in the long term, a drug-free society;
- creating detoxification services as the primary response to drug or alcohol problems;
- establishing comprehensive services for both alcohol and drug problems, including diagnostic services, emergency services, inpatient and outpatient programmes, after-care, and epidemiological data collection;
- incorporating the primarily medical aspects of substance-abuse dependence under harm-reduction policies that frequently involve social service interventions and coordination with prevention programmes relating to AIDS and HIV infection;
- controlling the possession and use of illicit drugs as the primary national target, with some attention given to treatment associated with the criminal justice system;
- policies and national strategies that combine programmes related to drug and alcohol abuse;
- supporting and promoting expanded and efficacious treatment programmes, emphasizing rehabilitation and follow-up and promoting a therapeutic community approach;

- expansion and development of: integrated community programmes; regional ambulatory centres for withdrawal, psychosocial therapy and rehabilitation, regional inpatient centres for short-term treatment and protected housing, treatment communities for long-term treatment and centres for return to the community, and development of an appropriate system for users of methadone, to replace the current system;
- in an Islamic and ideological state [such as Pakistan] the abuse of narcotic drugs with its repercussions on the social structure cannot be permitted to proliferate;
- development of realistic harm-minimization strategies focused on preventing and reducing harm to individual drug-users, their families, workplaces and the wider community, while accepting that interventions that reduce risks of harm connected with drug use, without necessarily eliminating such use, can also have important benefits for both the individual user and the wider community.

Legislative changes have been made so that public health measures can be taken to discourage injecting drug use and to encourage entry into treatment or other health care programmes. In several jurisdictions, such changes have made possible increased methadone services, and lawful needle exchange and bleach distribution programmes, coupled with treatment.

Harm-reduction programmes have received increasing attention in relation to substance abuse, while “designated driver” programmes are a positive example of prevention in the alcohol field. Harm-reduction policy strategies and care programmes have emerged, particularly as applied to HIV transmission among injecting drug users. A further step links harm reduction as a bridge to substance-abuse treatment.

The international drug conventions act as a stimulus to governments to prepare national policies and strategies for drug-control and demand-reduction activities. The 10 years 1991-2000 have been designated the United Nations Decade Against Drug Abuse. The 1998 (20th) Special Session of the United Nations General Assembly, devoted to the countering of world drug problems (United Nations 1998a), as well as the United Nations Political Declaration and Global Programme of Action for international cooperation in the control of drug abuse and illicit trafficking in narcotic drugs and psychotropic substances (United Nations, 1990a) urges governments to take specific action in respect of the treatment, rehabilitation and social reintegration of drug-dependent persons. National strategies in the health, social, legal and criminal fields should contain programmes for the social reintegration, rehabilitation and treatment of drug-abusers and drug-dependent offenders. Such programmes must be in

conformity with national laws and regulations and be based on respect for basic human rights and the dignity of the individual (United Nations, 1990a)<sup>1</sup>.

The Declaration of the International Conference on Drug Abuse and Illicit Trafficking and Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control, published in 1988 (United Nations, 1988), emphasizes, under target 29, that a clear and precise policy on treatment is fundamental to the conduct of treatment operations. According to the Outline, the policy should be one which permits a choice of objectives and the establishment of an order of priorities. The establishment of national coordinating bodies responsible for coordinating and guiding the development and maintenance of comprehensive treatment programmes for drug-dependent persons, was also urged under target 29. Detoxification alone was not considered sufficient, as it represents only a part of the treatment and rehabilitation process. The policy recommendation under target 31 is that detoxification must be succeeded by rehabilitation, a long process aimed at returning the individual to productive civic life. Moreover, under the same target, it is recommended that persons in charge of treatment centres should be able to carry out individualized treatment programmes geared to the drug-dependent person's unique problems, and should ideally involve that person's family. The treatment should, according to target 31, include pharmacological or psychotherapeutic treatment, social assistance, and participation in a community group process, and be chosen on the basis of what is truly effective, in addition to considerations of cost.

As noted previously in Chapter 1, the WHO Expert Committee on Drug Dependence, in its twenty-eighth report published in 1993 (World Health Organization, 1993c), urged that the development of treatment services for drug-related problems should be integrated with that of the mental health services, primary care and general health services, and sufficient resources should be allocated to maximize their effectiveness. To the extent possible, demand-reduction programmes should be based on a comprehensive approach to all potentially harmful psychoactive drugs. Thus attention must be paid not only to illicit drugs, but also to alcohol and tobacco, medicinal psychoactive drugs and volatile solvents to ensure that a reduction in health problems due to illicit drug use will not be offset by an increase in problems due to the use of other drugs. The Committee stressed the need for collaboration among the sectors involved in both control and demand functions. Since the sectors involved will vary between countries, it was considered that they would probably include a wide range of government agencies, nongovernmental organizations, and community organizations.

The Committee recommended that country-level policy-makers should regard treatment as a long-term process that seeks to motivate, enable or empower the individual concerned to deal constructively with his or her own problems. Treatment

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<sup>1</sup> See Chapter 5 (5.3) for the text of the applicable paragraphs.

programmes should be responsive to the complete range of needs of individual drug-users and their families. The policy should be communicated to the community so that people in need will know what treatment programmes are available, what they contain, and what they seek to achieve. Drug-users will then be encouraged to seek help and will also gain public acceptance. The Committee urged that such treatment programmes should also assist in the reintegration and rehabilitation of treated drug-users in the community and, while based on primary health care, should strengthen collaboration with other community-oriented services and specialized services. In addition, policies should encourage and develop treatment services that reduce HIV transmission resulting from needle sharing or sexual activity.

The Committee urged that the primary goal of national demand-reduction programmes should be to minimize the harm associated with the use of alcohol, tobacco and other psychoactive drugs, while recognizing that, although some countries may decide to aim for the complete eradication of the use of a particular drug, others may consider such an aim as impractical or even undesirable. It recommended that, for maximum effectiveness, national policies should have explicitly defined "harm-minimization" goals, with both short-term and long-term objectives. Finally, the Committee urged that policies should address, in particular, human rights issues and the protection of individual rights in several contexts, e.g. in compulsory treatment within the penal system, in data protection, in access to treatment and social assistance, and in drug testing in the workplace.

## **7.2 Comparative review**

The sections which follow present the results of our survey of published documents on official government (national and subnational) drug and alcohol policies concerning treatment and rehabilitation goals and objectives. Information is given separately for each of the six WHO regions. While all governments may have adopted policies, not all are presented in a published strategy document, so that this review is not intended to be comprehensive. References to the published documents are provided, thereby permitting the reader to review the authoritative official government policies in more detail. Reference should be made to official government policy statements for a comprehensive understanding of government policies.

The legislative foundations of treatment and rehabilitation are analysed in Chapters 10-15.

In some countries (India, Viet Nam, Zimbabwe), State constitutions, in addition to executive branch directives, and legislation, expressly guide policy requirements. For example, the constitutions of Viet Nam and Zimbabwe contain provisions on treatment for drug dependence. The Constitution of the Socialist Republic of Viet Nam, adopted on 15 April 1992, prohibits the production, possession, traffic, storage and illegal use of opium and other narcotics. Moreover, the "State

stipulates a mandatory system for weaning addicts and for treating other dangerous social diseases". The Constitution of Zimbabwe, as amended on 1 August 1985, provides that no person shall be deprived of his personal liberty except as may be authorized by law in any of the cases enumerated in Section 13 (2). Deprivation of liberty is permitted if a person "is, or is reasonably suspected to be, of unsound mind, addicted to drugs or alcohol, or a vagrant, for the purpose of his care, treatment or rehabilitation or the protection of the community". In India, Article 47 of the Constitution imposes a duty upon the State to raise the level of nutrition and the standard of living of its people and improve public health. The State must bring about the prohibition of the consumption of intoxicating drinks, except for medical purposes.

### 7.2.1 *African Region*

In the WHO African Region, we reviewed the published official government (national and subnational) drug and alcohol policy documents of Nigeria, South Africa and Zimbabwe.

We reviewed two Nigerian policy documents, namely the National Health Policy and Strategy to achieve Health for All Nigerians, published by the Federal Ministry of Health, (Nigeria, 1988), and the National Mental Health Policy for Nigeria of 1991 (Nigeria, 1991). In the latter, the Government of Nigeria affirms that health, including mental well-being, is the inalienable right of every Nigerian, and that mental health care must be made available to all citizens within a national health system based on primary health care. Moreover, the objectives of the federal, state and local governments must include the following:

Alcohol and drug abuse and their associated problems shall be reduced to the barest minimum by the use of appropriate preventive, therapeutic and rehabilitative measures.

In South Africa, the National Drug Master Plan was prepared in 1998 and transmitted by President Mandela in March 1999 (South Africa, 1999). The National Drug Master Plan supports general guidelines on how the welfare sector will address substance abuse treatment: (1) intersectoral approach; (2) focus on high risk groups, using employee assistance programmes and youth forums; (3) focus on vulnerable and high risk groups and disadvantaged communities, and development and promotion of community-based treatment approaches especially those that promote empowerment and self-help; (4) establishment of specialized accredited training units to provide training of substance abuse forums at national, regional and local levels, to lobby for establishment of effective services; and (5) development of treatment services for children and youth using abusing volatile substances (South Africa, 1999). The aforementioned guidelines are consistent with principles, guidelines and recommendations found in the White Paper For Social Welfare, published by the South African Department of Welfare in August 1997 (South Africa, 1997).

In Zimbabwe, a draft policy (Republic of Zimbabwe, 1993) on the treatment and rehabilitation of alcohol- and drug-abusers was submitted in December 1993 to the Minister of Public Service Labour and Social Welfare for approval and submission to Parliament (R. Dzvova, personal communication, 1994). This draft policy is aimed not only at drug- and alcohol-dependent persons but also at all segments of society. Its components include counselling, guidance, motivation, medical treatment (including detoxification), rehabilitation and social reintegration. The treatment and rehabilitation activities will form an integral part of primary health care. Consequently, alcohol and drug treatment and rehabilitation services will be decentralized and integrated into existing health care and community services, making as much use as possible of the existing facilities and personnel at the community, district, provincial and national levels.

### 7.2.2 *Region of the Americas*

In the Region of the Americas we reviewed the published official government (national and subnational) drug and alcohol policy documents of Canada (Nova Scotia, Ontario) and the United States of America (Federal).

In the Canadian province of Nova Scotia, the Strategic Plan of the Department of Health, Drug Dependency Services Division, of October 1993 (Nova Scotia, Canada, 1993) is based on the view that alcohol, other drugs and gambling all require individuals to make responsible choices. According to the Plan, service standards and outcomes must be defined and drug dependency services must increase treatment options and make treatment more accessible. Communities will be assisted to develop early intervention expertise through information, education and training. In Ontario, treatment is considered as health recovery. The health recovery objectives of Partners in Action, Ontario's substance-abuse strategy, prepared by the provincial Ministry of Health in 1993 (Ontario, Canada, 1993) are:

- to establish a range of treatment services across the province, reflecting local priorities and needs, addressing special needs, and accessible to all;
- to implement province-wide standards for the quality of care;
- to shift emphasis from institutional treatment to flexible, effective, community-based care;
- to emphasize services to detect and treat substance abuse in its early stages;
- to address shortages of services; for example, for children and youth (especially those with both mental illness and chemical addiction) and for women.

While residential inpatient treatment is considered an important part of the treatment system in Ontario, non-residential treatment is considered to be equally



effective, at the same or lower cost. The Ontario strategy recommends a shift to non-residential treatment, consistent with the Government's Vision of Health and Health Goals. Ontario's substance-abuse strategy also recommends: (a) developing common standards, to be consistently applied across the province; (b) special education; and (c) in-service training for those working with people with alcohol and other drug problems, or with a combination of mental illness and drug problems (Ontario, Canada, 1993).

In Colombia, we reviewed the National Plan of Action Against Drugs (1999-2001) providing for state support of some treatment with the institutions offering permanent counselling to parents and their drug consuming children (Columbia, 1999).

In the United States of America, the documents that we reviewed at the federal level were: (1) the series of National Drug Control Strategies issued annually (since 1989) by the White House, e.g. National Drug Control Strategy (1998), a Ten-Year Plan (the 1998 Strategy) (United States, 1998a); and (2) the series of Strategic Plans prepared by the Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Plan of March 1993 (the SAMHSA Plan) (United States, 1993). The Anti-Drug Abuse Act of 1988 requires the Federal government to produce in its annual reports a comprehensive national strategy which details the resources committed to implement it and includes measurable goals. The 1998 Strategy states a ten-year framework plan to reduce illegal drug use and availability of 50 percent by the year 2007, which would result in 3.1 percent of the population aged 12 and over using illegal drugs. As of the 1998 Strategy, drug treatment in the United States is available for only 52 percent of persons who need it, despite 33 percent increase in federal expenditures for treatment since 1993. Accordingly, the 1998 Strategy supports and promotes effective, efficient and accessible drug treatments<sup>2</sup>. Two major developments marked the 1995 Strategy (focus on hard-core drug users) and in the 1998 Strategy (5 goals and supporting objectives). One of the principles of the 1995 Strategy is that drug treatment must target chronic, hard-core drug users, both within and outside the criminal justice system, to reduce their drug use and its consequences. The goals of the 1995 Strategy (United States, 1995) also include: (1) the expansion of treatment capacity and services and increased treatment effectiveness so that those who need treatment receive it; and (2) the targeting of intensive treatment services for chronic, hard-core drug-using populations and special populations, including adults and adolescents in custody or under the supervision of the criminal justice system, pregnant women, and women with dependent children. Substance-abuse treatment can reduce hard-core drug use and its consequences to both users and society. The 1995 plan defines chronic, hard-core drug users as addicted drug users who consume illicit drugs

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<sup>2</sup> By 2002, as part of its System for Assessing the Performance of the National Drug Control Strategy, will establish National Treatment Outcomes Monitoring System (NTOMS) to track effectiveness of treatment in all public and private sectors of the substance abuse treatment system including alcohol and drug use, medical problems, employment/financial problems, illegal activity, family/social problems, and psychological problems (United States, 1998b).

at least on a weekly basis and exhibit behavioural problems stemming from their drug use. Another goal is the reduction of the use of alcohol and tobacco products among underage youths. The 1996 Strategy (United States, 1996) was different in that, it established five major goals and 32 supporting objectives as the basis for a long-term rationale which remains the center of the 1998 Strategy (United States, 1998a).

In the United States of America, as of 1994, the Clinton administration attached greater importance than ever before, both programmatically and financially, to demand-reduction.<sup>16</sup> The budget prepared by the President for the new administration brought supply- and demand-reduction approaches into better balance. The Clinton Administration also elevated the Director of the Office of National Drug Control Policy (ONDCP) to Cabinet status. Increased attention was devoted to science-based research and data collection and how drugs, behaviour and environment may influence brain function. Research reported in several studies (United States, 1997a, 1997b) concluded that treatment reduces drug use; all types of treatment programmes can be effective; criminal activity declines after treatment, health improves after treatment, and treatment improves overall well-being (United States, 1998a). Research into the cost effectiveness of treatment for cocaine dependence (National Opinion Research Centre and Lewin-VHI, Inc., 1994a) concluded that US\$ 1 spent on drug treatment was worth US\$ 7 spent on the most successful law-enforcement efforts to curb the use of cocaine. The 1995 National Drug Control Strategy (which coordinates all Federal drug-control programmes), released in February 1995 (United States, 1995), sought to improve drug treatment and prevention through proposing consolidation of Federal drug treatment grants to the states, along with the elimination of federally mandated requirements to provide states with the maximum flexibility to determine and meet what they consider to be their most urgent drug treatment needs. The major funding components of such treatment include drug courts, substance-abuse treatment in Federal prisons, and substance-abuse treatment in state prisons. For fiscal year 1996, the total drug-control budget request for drug treatment of US\$ 2.8 billion represented an increase of US\$ 180 million over the 1995 levels.

The SAMHSA plan, and the discussion at the Harvard Advisory Group meeting are considered in Chapter 8.

### 7.2.3 *Eastern Mediterranean Region*

In the Eastern Mediterranean Region we reviewed the published official government (national and subnational) drug and alcohol policy documents of Bahrain, Egypt, Iraq, Morocco, Pakistan, and the United Arab Emirates.

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<sup>16</sup> Participants at the Harvard Advisory Group meeting addressed the planning and implementation of the treatment and rehabilitation components of national drug policies for governments in transition, and this paragraph incorporates the principal elements of a paper presented at the meeting by Dr Camille Barry (C. Barry, unpublished observations, 1994).

For Pakistan, we examined the Government Planning Commission's, Seventh Five-Year Plan (1988-1993) and Perspective Plan (1988-2003), report of the Working Group on Mental Health Care in Pakistan (Pakistan, 1987). The Five-Year Plan emphasizes that the goal of health for all by the year 2000 cannot be achieved unless approaches and strategies for the improvement of all aspects of health, i.e. physical, mental and social, are included in the health-care delivery system. The treatment and rehabilitation of drug-dependent persons "should be entirely the responsibility of the health department" and be a component of the mental-health-care delivery system, but implemented as a part of the public health and general health-care delivery system, not as a separate programme (Pakistan, 1987).

As previously noted, Pakistan has emphasized the influence of Islam on its policy in the following terms: in an Islamic and ideological state such as Pakistan, the abuse of narcotic drugs with its repercussions on the social structure cannot be permitted to proliferate (Pakistan, 1989).

#### 7.2.4 *European Region*

In the European Region we reviewed the published official government (national and subnational) drug and alcohol policy documents of Austria, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Israel, Italy, Kazakhstan, Latvia, Malta, Netherlands, Norway, Poland, Portugal, Russian Federation, Slovakia, Spain, Sweden, Switzerland, Ukraine, and the United Kingdom.

In Austria, *Report on the Drug Situation 1998*, commissioned by the European Monitoring Centre for Drugs and Drug Addiction and the Austrian Federal Ministry of Labour, Health and Social Affairs, reports that the main objective of the Austrian drug policy is a society as free of addiction as possible. In addition to approaches aimed at complete abstinence, the objectives of limiting drug-related risks and damages is emphasized also. (Austria, 1998).

For Denmark, *Drug abuse control in Denmark, a review* (1993), published by the Ministry of Health, was reviewed (Denmark, 1993). The Ministry of Social Affairs is responsible for treatment in institutions, housing projects and other projects providing care under the Social Security Act (e.g. family care) while medical treatment, including methadone prescription, comes under the jurisdiction of the Ministry of Health; and the Ministry of Justice is responsible for treatment associated with the criminal justice system. Drug dependence is considered to be a complicated psychosocial problem. Achieving a drug-free society is not considered to be a realistic objective, and making the dependent person totally drug-free is no longer the only goal. Goals for drug-dependent persons include abstinence; resocialization; prescription of methadone as a method of treatment of opiate users; and any measure which may increase the persons' resources. Treatment of drug-dependent persons is voluntary at

municipal levels, and is also delivered to inpatients in hospitals. For alcohol dependence, the health and social authorities are required to provide treatment on a voluntary basis, with rehabilitation as the goal, not merely detoxification. It is also reported that the use of mental hospitals for the treatment of drug users has decreased steadily; such hospitals are used primarily for the treatment of persons who are both mentally ill and drug dependent. Private facilities are also used in the treatment of drug-dependent persons (Denmark, 1993).

In Finland, the strategy of the Ministry of Social and Health Affairs stating the Action Plan for years 1997-2001 is (Finland, 1997) to provide all people equal access to help, and treatment of drug addicts to include short-term treatment, detoxification, inpatient care, therapeutic communities and group therapy.

For Germany, the National Programme on Drug Abuse Control (Germany, 1990) was reviewed. In July 1999, it was reported by officials of the Federal Government (R. Harms, personal communication, 1999) that - "even though some parts of this programme (National Programme on Drug Abuse Control, measures for drug abuse control and help for addicts at risk, 1990, Bonn) are not quite up to date, the programme is still valid". Germany is a federal republic. Under the German Constitution, the subnational jurisdictions (the *Länder*), together with counties and communities, are responsible for health-care delivery. The national policy goals are total abstinence from illegal drugs; self-controlled moderate use of licit addictive substances, alcohol and tobacco; and use of medication strictly in accordance with medical prescription. The National Programme on Drug Abuse Control was adopted in 1990, in cooperation with the *Länder*. Programme goals include counselling, treatment, care, rehabilitation, and professional and social integration. Effective counselling and treatment programmes must be widely available, of sufficient capacity and easily accessible. Alternative counselling and treatment programmes must also be available in order to take into account specific situations and needs of addicts. Treatment received major political support from Chancellor Helmut Kohl, in his statement at the beginning of the meeting on 13 June 1990 which adopted the National Programme on Drug Abuse Control. The Chancellor emphasized that drug addicts are sick, and that they have a right to assistance, medical treatment and rehabilitation (Germany, 1990). The German strategy makes use of a number of different modalities, including (a) social work for long-term drug-dependents; (b) inpatient crisis intervention; and (c) care and consultation for HIV-infected drug-dependent persons in drug counselling centres. A basic principle of the drug policy is "therapy rather than punishment" (Germany, 1990). *The Drug and Addiction Report 1998*, issued by the Federal Ministry of Health (Germany, 1998) sets out the "basic elements and objectives of a new addiction and drug policy" of the federal coalition government. These include a wide range of services to be provided in each city region with approximately 100 000 population, as follows: (a) "low threshold contact" and outreach centres; (b) methadone maintenance; (c) pilot projects for "heroin maintenance" treatment of those opioid addicts who cannot be reached with methadone projects; (d) several specific projects

(such as long term and short term therapy, specific schemes directed at women, families, addicted foreign nationals) (Germany, 1998).

In Ireland, we reviewed the Government Strategy to Prevent Drug Abuse, of May 1991 (Ireland, 1991). Under Section 3.4 of the Government Strategy, the Government of Ireland:

accept[s] that the provision of services aimed at the achievement of [a] drug-free society *only* or harm reduction programmes *solely* are inappropriate.

The general objective is to make available a range of possible approaches and the means of access to the services most appropriate to the immediate needs and capabilities of the drug-dependent person. A fundamental consideration in this respect is to ensure that the services available are attractive and accessible in order to encourage drug users to make use of them and to motivate them to continue with treatment. The Strategy (under Section 3.8.5) urges that treatment programmes for drug-dependent persons must be linked to the delivery of adequate social and employment skills, recognizing that at the time (1991) there was "little formal contact ... between treatment agencies and the occupational rehabilitation services [and] ... no integrated approach to the treatment and the occupational and social re-integration of drug misusers". In 1999, also reviewed was the publication *Action Programme for the Millennium*, stating commitments of Partnership 2000, including drug abuse, prevention, detoxification and rehabilitation services for drug addicts linked directly to employment opportunities. Also, a drug court system was to be established involving court supervised treatment programmes as an alternative to criminal prosecution for less serious drug-related offences (Ireland, 1999). *The Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* recommended in its May 1997 report the development of properly supervised treatment programmes for "low risk" offenders who misuse drugs and are convicted of petty crimes, as an alternative to prison (Ireland, 1997).

For Israel, the Anti Drug Authority Policy on Treatment and Rehabilitation is given in the Policy handbook of the Authority, published in Jerusalem, in 1992 (Israel, 1992). Section 3 notes that treatment and rehabilitation combine medical, psychiatric, and psychological measures, implemented at the community, regional-district and national levels. Section 4 states that the long-term policy and priorities (1992-1997) are:

- (a) expansion and development of integrated community programmes in about 80 local authorities;
- (b) expansion and development of a total of 10 regional ambulatory stations, in addition to five existing ones, for withdrawal, psychosocial therapy and rehabilitation,

- (c) expansion and development of regional inpatient centres for short-term treatment and protected housing in one of the eight hostels in the country;
- (d) expansion and development of treatment communities for long-term treatment as well as centres for integrated return to the community; and
- (e) development of an appropriate system for users of methadone, to replace the current "Medicate" system, in coordination and cooperation with the regional ambulatory stations.

The main goal of the Netherlands alcohol and drugs policy is to minimize the risks involved in the use of these substances to the users themselves, their environment and society as a whole; and assistance to drug addicts is an important part of this goal, according to the Netherlands Ministry of Health, Welfare and Sports (Netherlands, 1999b). An important part of the addiction care is to achieve an alcohol- or drug-free existence and the goal is the improvement of physical and social functioning without this being aimed solely at ending the addiction (Netherlands, 1999b).

The specialized addiction care sector in the Netherlands is part of the mental health care sector. Activities include prevention, consultation, medical and social care, treatment and after care provided by a network of establishments at the local and other levels (Netherlands, 1999b).

For Norway, the main principle is that treatment should be voluntary and drug free (Norway, 1997). It is stated (Norway, 1993) that the aim of drug policy in Norway is "a society free from drugs ... and that all sale, possession and use of drugs is unlawful". In 1985, the alcohol-dependence treatment system became the responsibility of the county authorities which are responsible for medical and psychiatric care in institutions. The main objective of treatment and rehabilitation is comprehensive treatment at the county and municipal level. It is reported (Norway, 1993) that many persons use local health services in either psychiatric or general health facilities. Voluntary treatment is preferred, although provision for the compulsory commitment of young persons is made in the legislation (Child Welfare Law of 1992, see Section A2.1).

For Poland, we analysed the National Programme for Prevention of Drug Addiction (Poland, 1993). The Programme includes the following types of services: detoxification; rehabilitation; resocialization; street workers consulting; shelters and hostels; specialist clinics for HIV carriers; confidential telephone; wards for mental patients dependent on drugs; wards for substitute treatment with methadone for HIV-infected drug-dependent persons. It recognizes a need: (a) to change the Law No. 15 of 31 January 1985 on prevention of drug abuse to adjust to the present situation; and (b) to amend Polish law to bring it into line with international law, including the 1988 Convention.

In commentary (Mejer-Zahorowski, O., date not available), on the drug policy of the Polish government, it is reported that changes are being made in treatment and rehabilitation progress to meet current needs, with special emphasis on: counselling units that reach "street workers" who are drug dependent; new progress of intensive short-term programmes involving psychotherapy, including family members, particularly for young drug abusers and methadone programmes as well as harm reduction programmes, including needle exchange. Also, the National Programme for the Prevention of Alcohol-Related Problems and the National Health Programme, 1996-2005, are in effect (Poland, 1997).

In the Russian Federation, the purpose of the Resolution of 22 July 1993 of the Supreme Soviet of the Russian Federation on the Principles of State Policy in regard to Narcotics Control in the Russian Federation is to establish the conceptual basis of Russian State policy on narcotics control, especially as regards the administrative and legislative aspects, as well as in terms of the development of a single, coordinated, interagency programme. With regard to treatment, social rehabilitation and measures for the care of drug-dependent persons, the Resolution states the following: <sup>17, 18</sup>

The establishment of a system for treatment and rehabilitation of drug addicts and drug abusers is an important, independent part of State policy, which calls for: an improved strategy for the organization and development of the narcotics service for new conditions, taking account of drug addiction as a socially dangerous disease; improvement of the organization and equipment of drug- treatment services in prisons; recommendation that the Government of the Russian Federation and local authorities allocate finance and equipment for a network of addiction treatment centres, to provide the appropriate standards of quality on the basis of scientific analysis of the effectiveness of existing approaches to treatment and rehabilitation; recommendation that the Ministry of Health of the Russian Federation, the Russian Academy of Science and the Russian Academy of Medical Science, draft proposals for improvement of the staffing, financing and equipping of programmes of research into drug addiction, mental health and related fields, ensuring that they are comprehensive and coordinated; establishment of a State fund for the social support and rehabilitation of drug addicts, and support for charitable activity in that area; guaranteeing high quality of professional training and specialization for the staff of treatment and rehabilitation centres, including psychiatrists, psychologists and social workers; arrangements for preventive mental health work with families and relatives of drug addicts, encouraging them to take part in the process of rehabilitation; development and production of

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<sup>17</sup> English translation by WHO.

<sup>18</sup> R.I. Hasbulatov, Chairman of the Supreme Soviet of the Russian Federation, Moscow, House of the Russian Soviets, 23 July 1993, No. 5494-1.

new drugs for the treatment of addicts, particularly specific preparations; organization of the production or of the special importation of the modern medical equipment needed for addiction centres, including laboratory equipment for drugs testing of biological samples.

For Sweden, we examined six policy documents: (1) *Ministry of Health and Social Affairs Social Services Act and Care of Young Persons (Special Provision) Act/LVU and Care of Abusers (Special Provisions) Act/LVM, Sweden, 1998 (Sweden, 1998a)*; (2) *Swedish Drug Policy, a Preventive Strategy, Swedish Drug Policy in the 1990s, (Sweden, 1998b)*; (3) *Social and Caring Services in Sweden 1996 (Sweden, 1996)*; (4) *Drug Policy, the Swedish Experience, (Sweden, 1995a)*; (5) *Alcohol and Narcotics in Sweden (Sweden, 1995b)*; and (6) *Swedish Drug Policy (Sweden 1998b)*. Drug policy is a part of social policy. The goal of Swedish drug policy is a "drug-free society". One of its characteristics is close interaction between preventive measures, control policy and the treatment of drug-abusers. Care for drug-dependents is aimed at achieving a life without drugs (Sweden, 1998b). Psychiatric care includes treatment in special detoxification and rehabilitation departments, and in special residential treatment centres for drug-dependent persons who are also mentally ill. The programme "Offensive Drug Abuser Care" has involved the goal of reaching all injecting drug users with sampling, detoxification and treatment (Sweden, 1996). The goal of Swedish alcohol policy is to reduce the consumption of alcohol by 25 per cent by year 2000. (Sweden, 1996). Swedish drug policy is that drugs will never be permitted to be an integral part of society, and that drug abuse must remain an unacceptable behaviour, a marginal phenomenon.

*Limiting the aims of drug policy to merely "reducing the harmful effects of drugs" is to capitulate to illegal drug trafficking and to accept that drugs have come to stay in our societies. A limited aim of this kind is in practice a lowering of society's ambitions and sanctions the marginalization of certain group in society (Sweden, 1998b); (as modified 9 April, 1999).*

For Switzerland, several policy documents were reviewed: (a) *The Swiss Drug Policy, a fourfold approach with special consideration of the medical prescription of narcotics (Switzerland, 1999a)*; (b) *Spectra, Prevention and Health Promotion No. 16 (Switzerland 1999b)*; (c) *Spectra, Prevention and Health Promotion No. 14 (Switzerland, 1998c)*; (d) *Spectra, Prevention and Health Promotion No. 12 (Switzerland, 1998b)*; and (e) *Progress report to the Federal Council on the package of measures to reduce problems related to drug addiction, as of the end of December 1993 (Switzerland, 1994)*. It is reported (Switzerland, 1998a) that the Swiss Government's Alcohol Programme for 1998 aims to raise awareness among medical doctors, who will then be encouraged to discuss alcohol problems with their patients. On 13 June 1999, Swiss citizens voted in a national referendum to support programmes of prescription of heroin for severely addicted drug users; following 8 October 1998



legislation enacted by the Swiss Parliament authorizing the prescription programme (Switzerland 1999a).

The Federal government pursues a policy of providing a variety of treatment opportunities for drug-dependent persons, including in- and outpatient treatment, oriented towards abstinence, methadone maintenance treatment, and other types of substitution treatment. It advocates a harm-reduction approach that provides help for the survival of those persons not ready or willing to undergo treatment. However, the Federal Government, has only limited competence in the treatment domain, the major responsibility lying with the cantonal governments forming the Swiss Confederation (M. Rihs, personal communication, 1993). It is reported (Switzerland, 1999a) that the Federal Office of Public Health has given special attention in 1999 to: (1) close, coordinated collaboration among public health, police authorities, and welfare agencies to adopt a common strategy; and (2) scientific research and systematic evaluation measures.

A study carried out by the Institut universitaire de médecine sociale et préventif of Lausanne (Cattaneo, et al., 1993) recommended (Recommendation III.3) that a "wider range of treatments be made available to match the different types of drug dependence and drug user". The authors base this recommendation on the assumption, that certain treatments are better suited to certain types of dependence or stages of a drug-dependent person's drug-taking "career". As reported in March 1999, approximately 100 inpatient facilities designed specifically to provide drug therapy and rehabilitation, for a variety of treatment goals were in operation delivering inpatient therapy with the goal of abstinence and social reintegration. (Switzerland, 1999).

In Turkey, the *Turkish Drug Report '98* (Turkey, 1998) was reviewed, noting that the Turkish Penal Code 756 provides for no prosecution for drug abusers in possession of drugs or psychotropic substances for personal use and who apply for treatment prior to prosecution.

For the United Kingdom, we examined the following policy documents: (a) *Tackling Drugs to Build a Better Britain, The Government's 10 year Strategy for Tackling Drug Misuse* (United Kingdom, 1998a); (b) *Tackling Drugs to Build a Better Britain, The Government's 10 year Strategy for Tackling Drug Misuse, Guidance Notes* (United Kingdom, 1998b); and (c) *United Kingdom Performance Targets For 2008 and 2005, Annual Report 1999* (United Kingdom, 1999). The policy goal (United Kingdom, 1998a) is to enable people with drug problems to overcome them and live healthy and crime-free lives. The key objective is to increase participation of problem drug misusers, including persons in drug treatment programmes which have a positive impact on health and care. In regard to protecting communities from drug-related anti-social and criminal behaviour (United Kingdom, 1998b) the Plymouth and Torbay "Fast Track Assessment and Treatment Programme" enables drug misusing offenders who are committing property offenses [to buy drugs] to have "fast access to drug treatment services". It is reported (United Kingdom, 1998b) that the "fast track

assessment and treatment programme has been successful, measured as client reduction of drug intake, initiation of a settled life style, significant proportion electing to remain in treatment when probation order is completed, as well as a significant reduction in domestic burglary rates" (United Kingdom, 1998b).

### 7.2.5 South-East Asia Region

In the South-East Asia Region, we reviewed the published official government drug and alcohol policy documents of India, Sri Lanka, and Thailand. In India, the two relevant strategies reviewed are: (1) the Annual Report 1992-1993 of the Ministry of Welfare (India, 1992-1993); and (2) the Strategy for Drug Abuse Demand Reduction in India, 1993, prepared by the National Institute of Social Defence (H. Singh, 1993). The latter calls for the community-based identification, treatment and rehabilitation of drug-dependent persons, while the Annual Report emphasizes the expansion of the network of facilities for counselling, detoxification and after-care for both alcohol and drug dependence. In 1999, the Embassy of India (to the United States, in Washington D.C.) report *Social Objectives* states (India, 1999) that "there are 359 counselling centres for drug abuse prevention ... the Government finances 250 NGOs which are engaged in drug prevention activities. A tripartite agreement between the Government, ILO and UNDCP has been signed to help full rehabilitation and recovery of drug addicts" (India, 1999).

In Sri Lanka, the National Policy for the Prevention and Control of Drug Abuse was prepared by the Sri Lanka National Dangerous Drugs Control Board. The policy calls on the Board to coordinate both short- and long-term action plans, based on national priorities, keeping in mind local needs and suitably adapting the strategies outlined in the United Nations Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control, noting that General Assembly of the United Nations has on several occasions urged governments to use the Outline in the formulation of their own programmes (Sri Lanka, undated). The provisions of the Outline have been discussed in Chapter 5.

In Thailand, the Government of Thailand has prepared the National Strategy for Drugs Control (1992-1996), published in 1993 (Thailand, 1993). The ultimate goals of the policy - are "to disrupt drug production, to dismantle trafficking networks, and to minimize the harmful abuse of drugs and all addictive substances". The national priorities include (Thailand, 1993 at p.12):

supporting and promoting the expanded and efficacious treatment programme, giving particular attention to rehabilitation and follow-up stages as well as promoting therapeutic community.

At the local level, the Department of Health of the Bangkok Metropolitan Administration, through its Drug Abuse Prevention and Treatment Division, delivers

services through a network of narcotic clinics and rehabilitation centres, on an outpatient voluntary basis in four stages: (1) pre-admission orientation; (2) detoxification and methadone maintenance; (3) rehabilitation; and (4) after-care (Thailand, 1990).

## 7.2.6 Western Pacific Region

In the Western Pacific Region we reviewed published official government (national and subnational) drug and alcohol policy documents in Australia (Federal, New South Wales, Sydney, Western Australia), China (including Hong Kong Special Administrative Region, and Macao Special Administrative Region), Japan, Malaysia, New Zealand and Singapore.

The national policy documents reviewed in Australia (Federal) cover two national strategy planning periods: (1) 1993-1997 period; and (2) 1998-1999 to 2002-2003 period. The documents in the 1993-1997 period include: (a) *the National Drug Strategic Plan 1993-1997* (Australia, 1993a); (b) *the National Health Policy on Alcohol in Australia* (Australia, 1990); and (c) *the National Policy on Methadone* (Australia, 1993b). Australia has a federal system of government with six states and two territories, and these are responsible for the provision of services for treatment and rehabilitation. The National Drug Strategic Plan 1993-1997 (Australia, 1993c) was the Federal Government's five-year plan for national actions on drug dependence, and is based on the harm-minimization principle:

The principle of harm minimisation recognizes that there is a broad spectrum of levels of drug use, acute and chronic, and of associated risks of physical and social harm. It includes preventing anticipated harm and reducing actual harm. Harm minimisation demands realistic strategies focused on preventing and reducing harm to individual drug users, their families, workplaces and the wider community. It accepts that interventions that reduce risks of harm connected with drug use, without necessarily eliminating use, can also have important benefits for both the individual user and the wider community. Harm minimisation is consistent with a comprehensive approach to drug-related problems using a balance of supply control, demand reduction and problem prevention. A comprehensive approach must take into account three interacting components: the people involved, their social, physical and economic environment, and the drug itself. Harm minimisation involves a range of approaches to prevent and reduce drug-related harm, including prevention, early intervention, specialist treatment, supply control, safer drug use and abstinence.

The Federal Government's national health policy on alcohol is based on the principle of minimizing the harm associated with alcohol use, while interfering as little as possible with the freedom of individuals to exercise personal responsibility for the

use or non-use of alcoholic beverages. Treatment has a limited but vital role in a comprehensive policy aimed at the reduction of alcohol problems. As there is no single form of treatment which is effective for all individuals, a range of interventions should be available, and the person with the problem should be actively involved in defining the goals of treatment and the most appropriate methods of achieving them. Much of the intervention offered should take place on an outpatient basis, although there remains a need for some inpatient facilities. For heavily dependent people, treatment will need to be on an ongoing basis (Australia, 1990).

The 1998 report of the Federal Ministerial Council on Drug Strategy (Australia, 1998) evaluated the success of Australia's drug policy during the 1993-1997 period as being based on four main features: (1) principle of harm minimization, which recognizes the need to take a wide range of approaches in dealing with drug-related harm, such as supply-reduction, demand reduction, also including abstinence and harm reduction efforts; (2) an approach involving comprehensiveness - including alcohol, licit pharmaceutical drugs, tobacco; (3) linkages among law enforcement, health and community organizations addressing drug-related harm; and (4) a balanced approach between demand reduction, supply reduction, and harm reduction strategies - facilitating access to treatment and encouraging research, and coordination among communities, states and territories. Based on the evaluation, the federal government decided to continue the integrated approach (Australia, 1999).

While subnational jurisdictions differ in the extent and manner to which they provide methadone programmes in Australia, the national policy on methadone (Australia, 1993b) is based on the following principles:

- availability — where a need for methadone services exists these services should be made available;
- access — methadone services should be accessible to those targeted to use the services;
- acceptability — the operation of methadone services should be acceptable to major stakeholders;
- equity — methadone services should be planned and operated to reduce inequities between target groups in terms of access to, and quality of, services;
- accountability — those who manage and operate methadone services should be accountable for the performance of these services to key stakeholders.

In Australia (New South Wales), there are two policy strategies: (a) the New South Wales Drug Strategy 1993-1998, (New South Wales, 1993a); and (b) the New

South Wales Youth Alcohol Strategy, (New South Wales, 1993b). It is reported (New South Wales, 1993a) that the goals of the Drug Strategy include: (1) the provision of effective and accessible services to key target groups and communities to reduce drug related-harm; and (2) emphasis by alcohol and other drug-treatment services on drug substitution (methadone) and the development of early, brief therapeutic interventions. Harm-minimization policies focus "on the specific harms that can be caused by the use of particular drugs, by particular people, in particular circumstances", based on a recognition that there is a continuum of harm associated with the use of alcohol and other drugs, so that no single approach or limited set of strategies can adequately address the possible range of harms. Public hospitals, as well as community health services, provide treatment services for alcohol and other drug problems. Hospitals provide detoxification treatment, and many community health services incorporate alcohol and other drug health care into their services (New South Wales, 1993a).

The goal of the youth alcohol strategy (New South Wales, 1993b) is to promote the health and well-being of young people by minimizing the harm in terms of health, social, economic and environmental consequences associated with alcohol use in the 12-24 age group. A goal for 1998 is to increase the availability of attractive and appropriate treatment services for young people who experience alcohol-related problems. In the city of Sydney, the Southwestern Sydney Area Health Service has published a Drug and Alcohol Service Strategic Plan (Sydney, 1992). The plan has adopted a public health approach, the services ranging from prevention, education and brief interventions to intensive treatment and rehabilitation. Objectives include the provision of a range of treatment and rehabilitation options for people with major social, psychological and medical complications resulting from drug and alcohol use. Such services include medical services, methadone programmes and residential rehabilitation programmes. In Western Australia (Western Australia, 1997) the *Western Australian Strategy Against Drug Abuse Action Plan 1997-1999* emphasized a harm reduction approach to reduce the risks to drug abusers and the community while taking care that such approaches do not encourage or "normalize" drug use. Drug or alcohol-dependent offenders are to receive treatment during confinement or while serving community-based sentences.

For China, we reviewed a report published in the *Chinese Bulletin on Drug Dependence* on the enforcement of the administration of narcotics control in China, prepared by the Bureau of Drug Policy and Administration of the Ministry of Public Health, (Chen Yinqing, 1992). The control of narcotics has involved: (a) the prohibition of cultivating, and trafficking in narcotic drugs; and (b) improving the management of narcotics for medical use in order to meet the medical needs only, and "also to prevent their abuse and addiction". In furtherance of this policy, the Chinese Government has taken the following action (Chen Yinqing, 1992):

- "6. Priority provinces and autonomous regions, led by the government, have set up substance abuse clinics. Drug addicts are obliged to give up

drugs. There were 41 227 people in 1991 who received drug "stopping" therapy in the whole country.

"7. Strengthening academic research and technical guidance, the Ministry of Public Health established National Institutional of the research on Drug Dependence in Beijing Medical University in 1987, the National Center for the Treatment of Drug Abuse in 1988, and the National Laboratory on Narcotics in 1990, in order to strengthen academic research and technical guidance. Some provinces and municipalities have also established therapeutical and monitoring centres."

Also in China, we reviewed the Hong Kong Special Administrative Region Narcotic Reports before and after Hong Kong's return to China in 1997. According to the *Hong Kong Narcotics Report, 1998* (Hong Kong, 1998), the Hong Kong Government's "multi-pronged" strategy for a drug-free Hong Kong combines: (1) law enforcement; (2) treatment and rehabilitation; (3) preventive education and publicity; (4) research; and (5) international cooperation. According to the Hong Kong Administrative Region government, Hong Kong has programmes of several different types for the treatment and rehabilitation of drug abusers (Hong Kong, 1999b). These include a compulsory placement programme operated by the Correctional Services Department; a voluntary methadone outpatient programme of the Department of Health; voluntary residential treatment programme of the Society for the Aid and Rehabilitation of Drug Abusers (SARDA) (Hong Kong, 1999b).

The 1999 Report of the Action Committee Against Narcotics (Hong Kong, 1999b) states three additional drug treatment and rehabilitation programmes: (1) counselling service provided by two teams of specially trained social workers from the Social Welfare Department to help young persons who are experimenting with drugs; (2) counselling services for psychotropic substance abusers; and (3) six substance abuse clinics operated by the Hospital Authority (Hong Kong, 1999b).

Treatment and rehabilitation activities in Hong Kong are also discussed in Chapter 4 in the context of self-help and mutual-support organizations.

For Japan, we reviewed information in documents covering policies on treatment and rehabilitation: (a) *Outline of drug abuse and countermeasures in Japan*, (Japan, 1993); and (b) *The 1998 Ministry of Health and Welfare Report on Administrative Measures Against Narcotics and Stimulants* (Japan, 1998). As reported in 1998, stimulant abuse is the most serious type of drug abuse in Japan; many long term stimulant abusers develop mental disorders from stimulant addiction (Japan, 1998). As stated in the 1998 report, in general, the three types of activities used are: (1) "host-focused" measures to control abusers, addicts and criminals and to provide medical treatment when necessary; (2) "agent-focused" measures to control the drugs; and (3) "environment-focused" measures used to rectify the social environment,

(Japan, 1998). In May 1998, a “Five-year Drug Abuse Prevention Strategy” was adopted by the government for the promotion of measures to prevent drug abuse, (Japan, 1998).

*The Outline of drug abuse and countermeasures in Japan*, (Japan, 1993) sets out the philosophy underlying the treatment for drug dependence:

To treat drug dependence, we mobilize specialists from diverse subject areas and non-specialists to support the individual's recovery from drug dependence. In doing so, we prepare the individual to tackle a broad range of therapeutic challenges, from the physical, mental and social aspects, which arise in the process of drug dependence.

In New Zealand we reviewed: (a) *The National Drug Policy*, issued by the Ministry of Health, July 1998 (New Zealand, 1998a); (b) *Drug Policy is National Plan For Action* (New Zealand 1998b); and (c) *Action on Hard Drugs and Cannabis Use* (New Zealand, 1999). The *National Drug Policy* is the Government's Five-Year (1998-2002) action plan for tobacco, alcohol, illicit and other drugs.

In 1999, the government's plan of action focused on addressing gaps and overlaps in drug and alcohol treatment services (New Zealand, 1999).

In Singapore, we reviewed the 1998 document, *Towards a Drug-Free Singapore, Strategies, Policies and Programmes Against Drugs* (Singapore, 1998), published by the Singapore National Council Against Drug Abuse. The “old” conventional approach for treating drug-dependent persons has been confinement, drug-free abstinence, and a “toughen-the-body” regime. Confinement was progressively longer - from 6 to 36 months - depending on prior records - for “cold turkey” detoxification, and physical exercise. The philosophy remains (Singapore, 1998) that a drug-dependent person should be fully accountable for their own actions, however, a “new” approach is for those determined to change, the government will adopt a compassionate and supportive approach. While the detoxification approach remains in place, so called “normal addicts” (those admitted for detoxification for the first time or second time), are separated from “hard core” addicts (those in confinement for three or more times) who go through extended prison-like institutional rehabilitation. The “normal addicts” are generally placed in a 6-12 month community-based rehabilitation and aftercare programme (Singapore, 1998).

