12. Treatment associated with the criminal justice system

12.1 General considerations

The 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987) noted that legislation establishing a national treatment programme for drug and alcohol dependence will not be complete without provisions for the diversion of drug-dependent persons from the criminal justice system. This is necessary because so many of those with either type of dependence almost inevitable become involved with the law-enforcement (and drug-control) agencies and the police at some time. Such diversion is consistent with the three international conventions on narcotic drugs and psychotropic substances[1].

Drug or alcohol dependence is a significant factor to be considered in the administration of the criminal justice system. It is important to identify the ways in which various countries manage the drug- or alcohol-dependent offender. The use of illicit dependence-producing drugs frequently makes the user subject to severe criminal penalties, including imprisonment or fine. In a few jurisdictions, less severe administrative penalties apply for persons who can demonstrate that the drugs in their possession were intended solely for personal use, at a dose level appropriate to their daily consumption levels and dependence. Alcohol is also a dependence-producing drug, but in most countries its consumption does not constitute an illegal activity. The alcohol abuser nevertheless frequently becomes involved in the criminal justice system, because alcohol can lead to behaviour that is dangerous to others, e.g. driving while under the influence of alcohol.

Some drug- and alcohol-dependent persons become involved in illegal activities for reasons that may be related to their dependence. The legislation of many countries provides for the treatment of drug- or alcohol-dependent offenders. In many instances, this involves managing them in the criminal justice system by placing them in a treatment setting, sometimes suspending punishment or providing treatment while they are in confinement.

For example, Judicial Standards, designed to guide courts and judges, in responding to criminal offenders and civil litigants who abuse substances have been adopted in some jurisdictions. For example, the Standards on Substance Abuse approved 28 April 1998, by the Justices of the Massachusetts Supreme Judicial Court,

[1] See Chapter 5 for a detailed discussion of these conventions: the 1961 Single Convention on Narcotic Substances, as amended in 1972; the 1971 Convention on Psychotropic Substances; and the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

urge courts to look for opportunities at each stage of proceedings to use the court authority to order reluctant parties into treatment (Massachusetts, 1998).

Of the total of 77 countries covered by the present survey, legislation providing for treatment associated with the criminal justice system was identified in 58 (See Annex 2, section A2.2). This type of legislation provides for a diversion from the criminal justice system into treatment and rehabilitation programmes. As in the 1986 WHO survey, we identified three types of diversion programmes, namely (1) for treatment pending or in lieu of trial (pre-trial diversion) ; (2) for treatment in lieu of imprisonment; and (3) for treatment concurrent with sentence. Some countries have enacted legislation in more than one of these three legislative categories. Many country-level survey respondents concluded that the objectives of the programmes for diversion from the criminal justice system for specialized treatment for drug dependence are actually being achieved. For example, some respondents observed that such diversion programmes, as an alternative to punishment, are an effective way of dealing with first-time or minor drug offenders. In countries imposing mandatory after-care follow-up enforced by courts, diversion programmes have been successful in keeping persons in after-care activities.

As noted in the 1986 WHO survey (Porter, Arif & Curran, 1986), one of the major policy questions facing legislators is whether diversion to treatment should be mandatory or merely made available for persons charged with certain serious offences, such as crimes of violence[2].

In Brazil, Law 6368 provides that, for persons dependent on narcotic drugs or on substances causing physical or psychic dependence, diversion to treatment may be ordered. A drug-dependent person who has committed a punishable offence and has been sentenced to a term of imprisonment or custodial security measure must undergo treatment in the clinic attached to the correctional establishment where he is serving his sentence. Where the judge finds the accused not guilty as a result of official expert evidence that his dependence, at the time a criminal act was committed, made him totally incapable of understanding the unlawful nature of his conduct or of acting on such an understanding, he must order the accused to undergo medical treatment. It is reported (Flach, unpublished observations) however, that there are no treatment programmes in the prisons for drug-dependent prisoners; and that the Law is in need of updating so as to move away from very harsh punishment for all drug offenders, such as "irrational severity" in the imposing of criminal penalties on drug users. Respondents (R. Feix; J.C. Fernandes Galduroz; N. Shuqaira, personal communications, 1994) in the

[2] Participants at the Harvard Advisory Group meeting addressed treatment and rehabilitation associated with the criminal justic system. The following paragraph presents the main elements of a paper presented by Judge L.M. Flach at the Advisory Group meeting on criminal justice systems (L.M. Flach, unpublished observations, 1994). Formerly a District Judge of the State of Rio Grande do Sul in Brazil. Judge Flach confirmed that Law No. 6368 (see Annex 2, section 2.2) is still in effect.

present survey reported that revisions to Law No. 6368 are under consideration in the National Congress of Brazil.

12.2 Diversion

When diversion to treatment is mandatory prior to or instead of trial, this decision can be viewed as a decriminalization of the person's conduct.

Treatment pending or in lieu of trial (pretrial diversion) includes diversion to treatment for drug- or alcohol-dependent persons involved in the criminal justice system up to, but not including, trial for a criminal offence. Of the 58 countries and territories having diversion legislation (summarized in Annex 2, section A2.2), 17 had provisions in this category, namely Chile, Costa Rica, Egypt, France, Germany, Hungary, Jordan, Kuwait, Lithuania, Peru, Philippines, Qatar, Senegal, Sweden, Thailand, United Arab Emirates, and the United States of America (Connecticut, Massachusetts). There were several types of pretrial diversion in the legislation, as described below.

The first relates to persons who are liable to arrest for the commission of an offence, are taken into custody by law-enforcement personnel, but are in need of emergency treatment because of acute drug- or alcohol-induced incapacity. Typically, such situations involve the need for short-term (e.g. 24 B 48 hour) alcohol detoxification. The alcohol- or drug-dependent person is not arrested but taken, either at his own request or involuntarily, to a suitable treatment facility for a limited period and then either released or charged with an offence.

A second type of pretrial diversion concerns persons making illicit use of narcotic or other drugs (but not alcohol) or persons who are found in an intoxicated condition in violation of penal provisions, and who are put under surveillance and into treatment. In France, for example, on the basis of a medical examination of the person and an investigation into his family, professional and social life, Law No. 70-1320 of 31 December 1970 permits medical surveillance (for as long as necessary) of narcotic-dependent persons, including outpatient treatment, in lieu of trial, either by a physician of the dependent person's choice, or by a social hygiene clinic or approved health establishment. These services may be either public or private. Health authorities must follow the progress of the treatment and at regular intervals inform the public prosecutor's office of the medical and social situation of the person.

A third type of pretrial diversion concerns a person currently undergoing treatment under a compulsory civil commitment law and suspected of a criminal offence committed before the treatment began or during the treatment period. The prosecutor may then consider whether it is appropriate to prosecute. Provisions for this type of approach are found in Sweden.

Finally, there are persons who have been arrested and thereafter are determined to be drug-dependent by medical examination, conducted either at the person's own request or by judicial authority. Where treatment is ordered after medical examination and successfully completed, prosecution may be waived. Such provisions are contained, for example, in the legislation of France, Germany, Philippines, and the United States of America (Connecticut, Massachusetts).

Examples of provisions for treatment in lieu of trial are found in the legislation of Egypt, France, Germany, Hungary, Qatar, United Arab Emirates and the United States of America (Federal, Connecticut, Massachusetts). In France, under Law No. 70-1320 of 31 December 1970, persons who have complied with prescribed medical treatment for narcotic dependence and have completed it are not liable to prosecution. In Germany, under Section 37 of the Notice of 1 March 1994 promulgating the revised versions of the Narcotics Law, if an accused person is suspected of having committed a crime as a consequence of narcotic drug dependence and the penalty is imprisonment for a period not exceeding two years, the public prosecutor may refrain from prosecution if the accused proves that he has been undergoing treatment for at least three months and that rehabilitation is to be expected. In Hungary, under the Criminal Code Amendments of 15 May 1993, a person cannot be punished who cultivates, produces, purchases or keeps a small quantity of narcotic drugs for personal use or commits an offence punishable by confinement for less than two years connected with the consumption of narcotic drugs, provided that before sentencing (first instance) the person certifies in writing participation in a continuous treatment of at least six months. In the United States of America (Connecticut), under Chapter 329 of the General Statutes of Connecticut, a court may order suspension of prosecution and treatment for alcohol or drug dependence if, after considering information before it concerning the alcohol or drug dependence of the person, including an examination report, it finds that: (1) the accused person was an alcohol-dependent or drug-dependent person at the time of the crime; (2) the person currently needs and is likely to benefit from treatment for the dependency; and (3) suspension of prosecution will advance the interests of justice. A suspension of prosecution may be ordered for a period not exceeding two years. During the period of suspension, the accused person must be placed in the custody of the office of adult probation for treatment for alcohol or drug dependence. The court or the office of adult probation may require that the person must: (1) comply with any of the conditions specified in the law; and (2) be tested for use of alcohol or drugs during the period of suspension. The accused person must, unless indigent, pay the cost of the treatment ordered.

Examples of provision for treatment pending trial are found in the legislation of Costa Rica, Peru, the Philippines and Sweden. In Peru, under the Penal Code, when compulsory hospitalization is ordered for a drug- or alcohol-dependent person who is charged with a crime, the court must arrange for compulsory hospitalization to take place before the sentence is decided. The period of compulsory hospitalization is deducted from the duration of the sentence, without prejudice to the power the court to annul it or reduce its duration, depending on the success of treatment. In the Philippines

under the Dangerous Drug Act of 30 March 1972, as amended, if a person is charged with an offence and found to be a drug-dependant, the court may order treatment and, following successful rehabilitation, he may be returned to the court for trial. If he is convicted, the court may then elect to reduce the period of confinement by taking the treatment period into account. In Sweden, if a person for whom treatment has been provided under the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents (Special Provisions) Act/LVM/ (SFS:1988:870), dated 1 January 1989, as amended, is suspected of a criminal offence subject to public prosecution and for which the punishment is not more than imprisonment for one year, and if the offence was committed before the treatment began or during the treatment period, the prosecutor must consider whether it is appropriate to prosecute. The governing body of the home where the suspect is receiving treatment or, if treatment has ceased, the social welfare board, must be consulted in the matter unless this is unnecessary.

Voluntary application for treatment in designated facilities acts as a bar to criminal proceedings for certain drug-related offences in Egypt, Jordan, Lithuania, Philippines, Qatar, Seychelles, Thailand, United Arab Emirates and Venezuela. As previously pointed out in section 10.1, "voluntary" care can take a number of different forms, and those seeking it include both what are called "spontaneous clients and "willing or voluntary clients". The second category includes a wider spectrum of persons whose reluctance to seek treatment is overcome, e.g. by the fear of criminal prosecution if no effort is made to seek treatment. For example, in Egypt under Law No. 122 of 1989, action will not be taken against a user of narcotic substances who reports voluntarily, and remains in designated sanatoria, or in the treatment institutions established for this purpose by the Minister of Social Affairs in agreement with the Minister of Public Health, in order to receive medical, psychological and social treatment, until the Committee decides otherwise. In Jordan, under the Law on Narcotic Drugs and Psychotropic Substances of 1988, no prosecution may be brought against a person addicted to narcotic drugs or psychotropic substances if he, of his own accord, comes forward requesting treatment or if such a request is made prior to trial. In Qatar, under Law No. 9, 1987, criminal proceedings will not be instituted against any person taking narcotic drugs who presents himself for treatment spontaneously. Following confirmation of addiction and the need for treatment after a two-week period of observation in a sanatorium, the person must sign a statement accepting his committal to the sanatorium for a period not exceeding three months. If he is "cured" within that period, the administration of the sanatorium must order his discharge. In the United Arab Emirates, under Federal Law No. 6 of 1986, no criminal proceedings will be instituted against a person who has taken psychoactive substances if he presents himself of his own accord to the sanatorium assigned or to the Public Prosecution and seeks treatment.

Legislation on *treatment in lieu of imprisonment* includes provisions for the suspension (or waiving) of execution of sentence after conviction, subject to the successful completion of treatment. Of the 58 countries or territories containing diversion legislation (summarized in Annex 2, section A2.2), 29 had provisions for

treatment in lieu of imprisonment, namely Afghanistan, Austria, Chile, China (Hong Kong, Macao), Egypt, Finland, Germany, India, Indonesia, Ireland, Israel, Italy, Jordan, Malaysia, Norway, Poland, Portugal, San Marino, Senegal, South Africa, Spain (Federal), Sweden, Switzerland (Federal) Thailand, Tonga, Trinidad and Tobago, United Kingdom, United States of America (Federal, Connecticut) and Zimbabwe. In Afghanistan, under the Law on Combating Drugs, 1991, instead of sentencing the drug addict to imprisonment, the court must order the addict's detention in a related health centre for treatment for not longer than two years. The health centre must report to the court through the prosecutor every 15 days on the health status of the drug-dependent person. On the basis of the report received, the court can nullify or extend the detention of the drug addict. In Austria, the Narcotic Drugs Act, 1951, as amended, is based on the principle of "treatment instead of punishment". Thus, under certain circumstances, criminal proceedings against a drug-dependent person can be suspended for a probation period of two years. In addition, if a prison sentence has already been imposed, its execution may be suspended to allow the convicted person to undergo treatment. If this is successful, a suspended sentence on probation may be granted. In Chile, under Act No. 18.403, if the examination ordered by the court indicates that the person is a habitual consumer of illicit drugs, the judge must order the person's immediate confinement in an establishment authorized by the National Health Service for the purpose of rehabilitation; alternatively, the judge may authorize such treatment without confinement, but subject to the medical supervision of the National Health Service. In Hong Kong, under the Drug Addiction Treatment Centres Ordinance, drug-dependent persons found guilty of an offence punishable by imprisonment are ordered to be detained in addiction-treatment centres in lieu of any other sentence. The court must be satisfied that, given the circumstances of the case and having regard to the person's character and previous conduct it is in both the person's and the public interest that the person should receive treatment and rehabilitation in such a centre. In India, under the Narcotic Drugs and Psychotropic Substances Act, 1985, the court, taking into account the age, character, previous behaviour, or physical or mental condition of an offender, may, instead of sentencing him at once to any imprisonment, with his consent, direct that the person be released to undergo medical treatment (detoxification or "de-addiction") by a hospital or an institution maintained or recognized by the Central Government. The person must also enter into a bond in the form prescribed by the Central Government, with or without sureties, to appear and furnish before the court within a period not exceeding one year, a report regarding the result of his medical treatment. The person must, in the interim, abstain from the commission of any offence. The court may release the person, on entering into a bond, if no (designated) offence has been committed for a period not exceeding three years. If the person fails to abstain from the commission of an offence, he must appear before the court and receive sentence when called upon during such period. In Jordan, under the Law on Narcotic Drugs and Psychotropic Substances of 1988, instead of sentencing a person to the punishment specified in the Law, the court may take any of the following measures against the offender as it deems necessary: (*a*) order placement under treatment in a sanatorium specialized in the treatment of persons addicted to narcotic drugs and psychotropic substances; or (*b*) order treatment in a clinic specialized in psychological

and social therapy for persons addicted to narcotic drugs and psychotropic substances, under the care of a psychiatrist or social specialist. In Poland, under Law No. 15 of 31 January 1985, when a drug-dependent person is sentenced to imprisonment for a crime connected with intoxicant or psychotropic drug use, and is given a suspended sentence, the court must order the person to undergo treatment and rehabilitation in an appropriate treatment and rehabilitation and readaptation facility, and place the person in the custody of a selected person, institution or social organization. In Spain, under Constitutional Law 1/1988 of 24 March 1988, the judge or court may grant a suspended sentence to offenders sentenced to imprisonment, for a period not exceeding two years, who committed the offence as a result of their dependence on toxic drugs, narcotics or psychotropic substances, subject to the following conditions: (*a*) the sentence states that the individual has been proved to be a drug addict and that the offence was committed as a result of this situation; (*b*) a duly accredited or authorized establishment or department provides adequate certification that the offender has been detoxificated or is undergoing detoxification treatment at the time when the suspended sentence is allowed; and (*c*) the individual is not a recidivist, and has not previously benefited from a suspended sentence. In Trinidad and Tobago, under the Dangerous Drugs Act, 1991, on conviction of a person who is in need of psychiatric care and treatment, the court before which a person is convicted for possession of any dangerous drug may, before imposing a sentence, order the psychiatric hospital director to admit the person convicted to the psychiatric hospital named in the order. When the psychiatric hospital director is satisfied that the patient is no longer in need of care and treatment, the court must rescind the order and deal with the person in such manner as it deems necessary. In the United Kingdom, under the Crime and Disorder Act 1998 (c.37), before making a drug treatment and testing order requiring a convicted offender to undergo treatment, for a period not less than six months and not more than three years as a resident or non-resident, for drug or alcohol dependence, the court must conclude that: (1) the offender is dependent on (or has the propensity to misuse) drugs; and (2) his or her dependency, or propensity, is such as requires and may be susceptible to treatment. In the United States of America (Connecticut), under Section 17a-656 of Chapter 329 of the General Statutes of Connecticut, the court may, after imposing sentence suspend execution of a sentence of imprisonment, either entirely or after a period set by the court, impose a period of probation and, as a condition of probation, order the office of adult probation to place the person in an appropriate treatment programme for alcohol- or drug-dependence. The court may require that a probation officer have at least one contact per week with the treatment programme in which the person is participating and at least one contact per week with the person when such person is not participating in an inpatient programme. These provisions do not apply to any person convicted of murder, attempt to commit murder, kidnapping, robbery in the first degree or any felony involving serious physical injury, or to any person who has been previously ordered to be treated under these provisions.

Legislation on *treatment concurrent with sentence* may be of several types, including: (i) treatment of convicted persons while serving prison terms; (ii) treatment prior to imprisonment, the time spent undergoing such treatment sometimes being

deducted from the prison term; or (iii) treatment as a condition of discharge from prison. Of the 58 countries and territories containing diversion legislation (summarized in Annex 2, Section A2.2), 33 had provisions in this category, namely Afghanistan, Argentina, Bahrain, Bolivia, Brazil, China (Federal, Hong Kong), Colombia, Czech Republic, Greece, Iran (Islamic Republic of), Israel, Kazakhstan, Latvia, Mauritius, Mexico, Myanmar, Netherlands, Nigeria, Paraguay, Peru, Philippines, Poland, Russian Federation, Seychelles, South Africa, Spain (Catalonia), Sweden, Tonga, Turkey, United States of America (Connecticut, Massachusetts), Venezuela and Zimbabwe.

The court may order treatment for drug dependence in addition to any penalty imposed for drug offences in Argentina (for an indeterminate period that must be completed first and is then counted as time served under the sentence, which it may not exceed); Bahrain (confinement to designated hospitals for treatment until such time as a committee created by a decision of the Minister of Health decides on the person's release from the hospital, subtracting the period of confinement from the term of the sentence); Bolivia (for an indefinite period, until such time as certainty regarding their rehabilitation has been established); Brazil (treatment in a clinic attached to the prison while serving the sentence); China (Federal) (those addicted to drugs must be forced to give them up and receive treatment and education); China (Hong Kong) ("a person may be transferred from prison to detention in an addiction treatment centre"); Colombia (for first-time and second offences, or "consumer" who, as verified by expert opinion, is in a state of drug addiction for the first time, confined in private or government-operated psychiatric or similar establishment for the period necessary for recovery); Czech Republic (treatment usually in addition to punishment); Greece (for persons possessing a small quantity for personal use, prison term in a special therapeutic prison or, in certain cases, a programme of consultation and support); Iran (Islamic Republic of) (drug addicts who are sentenced for illicit activities must be sentenced to the prescribed punishments, and are required to give up their addiction within six months); Israel (a drug "addicted" person is sentenced to imprisonment for six months or more, if the court concludes that the offence was a consequence of addiction which may lead to further offences; the court may, in its sentence, order that the person be detained in a closed institution "to be cured of that addiction"; the court may order probation under which he will receive treatment in a communal framework, for such period and in accordance with a programme as the court may direct; the court may make such an order for probation even if the court has not convicted the person); Mauritius (the person must undergo such treatment, education, after-care, rehabilitation or social reintegration as the court thinks appropriate and for such period not exceeding five years as the court specifies); Myanmar ("addicts" may be admitted for medical treatment to prison hospitals); Netherlands, (operational since summer 1998) (Netherlands, 1999c) "problematic addicted delinquents" who have committed several crimes and failed several treatment programmes may receive treatment in the forensic addiction clinic; also courts may order confinement for treatment of 18 months to 2 years, in a penal care facility for addicts; Nigeria (the tribunal before whom an accused is being convicted may, in addition to the punishment prescribed, order an offender to undergo measures such as treatment, education, after-care, rehabilitation or social

reintegration); Paraguay (when a person who has stood trial or been convicted for any offence is also a drug addict, he shall be subject, in addition to the penalty appropriate to his offence, to such measures of treatment in custody as his recovery may require, and treatment in custody shall be provided at an appropriate establishment determined by the judge and shall precede the serving of the sentence, the time spent in recovery being deducted from the duration of the sentence); Philippines (after rehabilitation, the person is returned to court for initiation or continuation of the prosecution of his case and, in case of conviction, all or part of the period spent undergoing treatment may be deducted from the sentence); Poland (a court may commit a person to treatment, before sentence is carried out, for a period of not less than six months or more than two years in the case of habitual use of alcohol or other intoxicant, and the court then reviews the sentence after discharge from the treatment institution in the light of the results of the treatment; (persons detained in reformatory schools and shelters for alcohol-dependent minors are required to follow prescribed treatment).

The countries and territories with legislation on treatment associated with the criminal justice system are listed in Table 11. Reference should be made to the individual legal texts if more detailed information is required.

Table 11

Countries or territories with provisions on treatment associated with the criminal justice system

Type of treatment	Country or territory
Treatment pending or in lieu of trial	Chile, Costa Rica, Egypt, France, Germany, Hungary, Jordan, Kuwait, Lithuania, Peru, Philippines, Qatar, Senegal, Sweden, Thailand, United Arab Emirates, United States of America (Connecticut, Massachusetts)
Treatment in lieu of imprisonment	Afghanistan, Austria, Chile, China (Hong Kong, Macao), Egypt, Finland, Germany, India, Indonesia, Ireland, Israel, Italy, Jordan, Malaysia, Norway, Poland, Portugal, San Marino, Senegal, South Africa, Spain (Federal), Sweden, Switzerland (Federal), Thailand, Tonga, Trinidad and Tobago, United Kingdom, United States of America (Federal, Connecticut), Zimbabwe

Table 11 *(continued)*

Type of treatment	Country or territory
Treatment concurrent with sentence	Afghanistan, Argentina, Bahrain, Bolivia, Brazil, China (Federal, Hong Kong), Colombia, Czech Republic, Greece, Iran (Islamic Republic of), Israel, Kazakhstan, Latvia, Mauritius, Mexico, Myanmar, Netherlands, Nigeria, Paraguay, Peru, Philippines, Poland, Russian Federation, Seychelles, South Africa, Spain (Catalonia), Sweden, Tonga, Turkey, United States of America (Massachusetts), Venezuela, Zimbabwe

In South Africa, a court may, in addition, or in lieu of any sentence order the person be detained at a rehabilitation treatment centre established under the Prevention and Treatment of Drug Dependency Act, 1992.

It is reported (V. E. Pelipas, personal communication, 1994) that, in the Russian Federation, the Criminal Code makes alcohol intoxication (in the commission of a crime) an aggravating circumstance. The court then reserves the right to recognize this circumstance, and may require a person convicted of a crime to undergo medical treatment for alcohol abuse. In Senegal under Law No. 75-81 of 9 July 1975, such a person may be required to remain in an approved institution for such period of his term of imprisonment for the offence as the court may specify in an order; any period served by a person in an institution will be counted as a similar period of imprisonment served for the offence pursuant to a sentence for the offence of which he has been convicted. In Spain (Catalonia), under Law No. 20 of 25 July 1985, the Department of Health and Social Security is responsible for collaborating with the Department of Justice in implementing detoxification programmes for prisoners dependent on "non-institutionalized drugs" (drugs not accepted by society). In Tonga, under the Mental Health Act, 1992, a person may be detained in hospital for treatment. The court must be satisfied, having due regard to the nature of the offence, and the character and antecedents of the offender, that such an order is the most suitable method of dealing with him and that arrangements have been made to admit the offender to hospital within a period not exceeding 28 days from the date of the order. In Turkey, under Article 404 of the Turkish Penal Code No. 765 of 1 March 1926, as amended, provides for drug abusers or people found in possession of drugs or psychotropic substances for personal use, imposition of prison sentences from one to two years, except for those persons applying to official authorities for treatment before prosecution commences -- who then are not prosecuted as a drug abuser. However, when a person using narcotics

has "attained the degree of addiction", that person must be referred to a hospital until medically regarded as "recovered". The court may also arrange, at any time during the hearings for the referral of addicts to hospitals for observation and treatment. In the United States of America (Massachusetts), under the Drug Rehabilitation Law of 24 December 1981, (a drug-dependent person may be ordered to undergo treatment at a correctional facility for all or part of his term of imprisonment. If the court does not order the defendant to be confined in such a facility, it may order that he be afforded treatment as a condition of probation. In Venezuela, under the Organic Law Governing Narcotic and Psychotropic Substances of 17 March 1984, if a person is found to be a "consumer" while imprisoned, treatment must be provided inside the correctional institution. In Zimbabwe, under the Inebriates Act, dated 4 December 1942, where an offence was committed by a person under the influence of "drink" or the person admits that drunkenness was a contributory cause of the offence and the person admits that he is, or is found by the court to be, an habitual drunkard or person convicted of the offence of drunkenness under the Liquor Act, 1984, the court may, in addition to or in substitution for any other sentence, order that the offender be detained for a period not exceeding three years at an inebriate reformatory and perform there such labour or work as may be prescribed by or under the provisions governing the reformatory.

12.3 Medical or other professional examination

Of the 58 countries and territories that have diversion systems, as reviewed in Annex 2, section A2.2, 29 provide for medical examinations (See Table 12). Such examinations usually involve at least one of four components: (1) an examination by medical or other personnel for the purpose of determining whether the person is dependent on drugs (or, in some jurisdictions, chronically abuses alcohol); (2) an assessment of the degree of drug dependence in relation to the quantity of drugs or plants seized (in jurisdictions where the judge's decisions depend on the person's consumption); (3) an assessment of the person's suitability for treatment; and (4) an opinion as to the appropriate treatment programme for the person.

Medical personnel conducting the examination are required to have specialized training or be an expert (e.g. psychiatrist, forensic expert) in the following jurisdictions: Austria, Brazil, Colombia, Israel, Paraguay, San Marino, Trinidad and Tobago, United States of America (Massachusetts), and Venezuela.

Either a physician or a competent medical practitioner must be designated in Bolivia, Chile, Egypt, France, Malaysia, Philippines, Senegal, and Tonga. A health board, or probation or welfare officer is responsible in Ireland, Qatar, and the United Arab Emirates. In Costa Rica, the Criminal Investigation Authority, and in Hong Kong, the Commissioner of Prisons, is responsible for making and submitting the required report.

While the majority of jurisdictions require a medical examination, more specialized criteria are found in Greece, where the tests to determine whether narcotics have been used include a toxicological analysis of body fluids and a supplementary detailed clinical examination). In Venezuela, a medical, psychiatric, psychological and forensic toxicological examination is required. In two jurisdictions (France, Senegal), an investigation into the person's family, professional, and social life must also be conducted. In Greece, under Regulation No. A.2b/ik.3982 of 7 October 1987, persons are declared dependent on narcotics if they meet at least three of the specified criteria including the consumption of narcotics, repeated attempts to control such consumption, interference with work, school performance, and social and other activities, continued use of narcotics although aware of the harmful consequences, increased tolerance levels, display of characteristic symptoms, and use of narcotics to attenuate such symptoms.

Reference should be made to the 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987) regarding the significance of medical examinations at every stage of the management of drug- or alcohol-dependent persons in the criminal justice system.

Table 12 shows the type of medical examination required, by whom it is conducted, and the scope of the examination in the various countries and territories.

Table 12

Medical examinations for treatment associated with the criminal justice system[1]

Country or territory	Type of medical examination and by whom conducted	Scope of examination
Afghanistan	Not stated	Not stated
Argentina	Not stated	Not stated
Austria	Medical expert opinion from a doctor sufficiently conversant with problems of drug abuse, on the charged person, taking into consideration the quantity of narcotic drugs acquired or possessed by person	Person
Bahrain	Not stated	Not stated

Table 12 *(continued)*

Country or territory	Type of medical examination and by whom conducted	Scope of examination
Bolivia	Institutes for drug dependence evaluate the condition of drug-dependent persons or drug addicts, and provide all technical information required by a competent authority	Person
Brazil	Official expert evidence. In the absence of official experts, the offender must be examined by medical practitioners appointed by the judge	Person
Chile	National Health Service determines whether or not the person is dependent on substances, and the degree of drug dependence	Person
China (Federal)	Not stated	Not stated
China (Hong Kong)	Report of the Commissioner of Prisons on the suitability of such person for cure and rehabilitation	Person
Colombia	Forensic medical opinion that person (user or consumer) is in a state of drug addiction	Person
Costa Rica	When judge establishes sale or possession is for the consumer's own use or personal consumption, the judge must take into account the medical report submitted by the Criminal Investigation Authority on consumer's degree of drug dependence in relation to the quantity of substances, drugs or plants seized	Person
Egypt	Person proven to be an addict	Person
France	Competent health authorities arrange for medical examination	Person, and investigation into family, professional and social life

Table 12 *(continued)*

Country or territory	Type of medical examination and by whom conducted	Scope of examination
Germany	Not stated	Not stated
Greece	Two medical tests. (*a*) Use of narcotics: test to determine whether narcotics have been used is a toxicological analysis of body fluids and a supplementary detailed clinical examination (*b*) Dependence on drugs: persons declared to be dependent on narcotics if they meet at least three of the following criteria: (1) they consume narcotics in greater quantities and for a longer time than they intended; (2) they have made repeated voluntary attempts, without success, to reduce or control consumption of narcotics; (3) they spend a considerable part of their time in obtainingand consuming, or recovering from the effects of, narcotics; (4) they are in a state of intoxication or display symptoms of the withdrawal syndrome from the drug, preventing satisfactory performance at work, school, etc.; (5) they discontinue important social professional, or study activities by reason of consumption of narcotics; (6) they continue to consume narcotics although aware of the chronic or long-term social, psychological, and physical problems thereby caused or aggravated; (7) they require constantly increasing quantities of the substances consumed; (8) they display characteristics of the syndrome; and (9) they frequently resort to narcotics to overcome the symptoms of the syndrome.	Person

Table 12 *(continued)*

Country or territory	Type of medical examination and by whom conducted	Scope of examination
India	Not stated	Not stated
Indonesia	Not stated	Not stated
Iran (Islamic Republic of)	Not stated	Not stated
Ireland	Health board, probation and welfare officer employed in the probation and welfare service of the Department of Justice, or other appropriate person or body accepted by the court, furnishes medical report to the court	Person
Israel	Opinion of psychiatrist that the accused is addicted to dangerous drugs	
Italy	For a drug addict or alcoholic under a prison sentence of not more than three years who is currently undergoing a rehabilitation programme, or intends to participate one, the offender's application must be accompanied by a certificate issued by the public health facility attesting to his status as a drug addict or alcoholic and the appropriateness of the agreed programme for the purposes of rehabilitating the offender	Person
Jordan	Not stated	Not stated
Malaysia	As a result of tests ("all such acts or procedures as may be carried out for the purpose of determining whether a person is drug dependent"), the person is certified by a government medical officer or a registered medical practitioner to be a drug-dependent	Person
Mauritius	Not stated	Not stated
Myanmar	Not stated	Not stated
Nigeria	Not stated	Not stated

Table 12 *(continued)*

Country or territory	Type of medical examination and by whom conducted	Scope of examination
Paraguay	Expert decision, submitted within 10 days, by the experts (specialist in forensic medicine, physician designated by the Ministry of Public Health and Social Welfare, and another physician engaged by the person in question if he or his legal representative so request)	Person
Peru	Not stated	Not stated
Philippines	Examination by two physicians who must report to the court	Person
Poland	Not stated	Not stated
Portugal	Gathered evidence or a medical statement show that the person is drug-addicted, to be proved as directed by the court	Person
Qatar	Board responsible for examining cases of persons committed to sanatoria, to be appointed by decree of the Minister of Public Health.	
San Marino	Expert opinion on subject's physical and psychological condition must always be ordered when the offender is to undergo a "probationary experiment". Such an expert examination will not be carried out when other and equivalent medical and health techniques for ascertaining or establishing the subject's condition have been used	Person

Table 12 *(continued)*

Country or territory	Type of medical examination and by whom conducted	Scope of examination
Senegal	By at least three physicians	Person; the person's family, professional, and social life must also be investigated
Seychelles	Person to be medically examined or observed by a medical practitioner. Where person in respect of whom an order has been made fails or neglects to appear for medical examination or observation, a police office may arrest him without a warrant and produce him before the medical practitioner specified in the order	Person
Thailand	After accused received at rehabilitation centre, the competent official must arrange for a verification examination quickly to find out whether the accused is addicted to narcotics or not, subject to the criteria and procedures for the verification examination prescribed in Ministerial Regulations	Person
Tonga	Written or oral evidence of two registered medical practitioners, that the offender is suffering from mental disorder of a nature and degree that warrants his detention in hospital for medical treatment	Person

Table 12 *(continued)*

Country or territory	Type of medical examination and by whom conducted	Scope of examination
Trinidad and Tobago	Psychiatric Hospital Director, as soon as practicable after admitting a person, shall make or cause to be made such psychiatric examination as is necessary for determining whether or not the person is in need of psychiatric care and treatment	Person
Turkey	The court may arrange, at any time during the hearings for referral of addicts for observation and treatment	Person
United Arab Emirates	Committee that supervises the treatment of addicts at the sanatorium assigned considers that the condition of the petitioner necessitates treatment at the sanatorium	Person
United Kingdom (England and Wales)	Court must conclude that offender is dependent on (or has the propensity to misuse) drugs or alcohol; his or her dependency (or misuse) caused or contributed to the offence in respect of which the order is proposed to be made; and his or her dependency is such as requires and may be susceptible to treatment	Person
United States of America (Federal)	Two qualified physicians examine person to decide whether he is a "narcotic addict" and likely to be rehabilitated through treatment	Person

Table 12 *(continued)*

Country or territory	Type of medical examination and by whom conducted	Scope of examination
United States of America (Connecticut)	An examining committee of one or more members of the clinical staff of the facility conducts examinations for alcohol or drug dependency. Examining committee must determine whether the person being examined was an alcohol dependent or drug dependent person at the time of the crime. If person is determined to have been dependent on alcohol or drugs, the committee must further determine (1) the history and pattern of the dependency, and (2) whether the person presently needs and is likely to benefit from treatment for the dependency	Person
United States of America (Massachusetts)	Upon request by defendant or by a psychiatrist (or if impracticable, a physician) who reports findings as to drug dependence of defendant	Person
Venezuela	Medical, psychiatric, psychological and forensic toxicological examination by at least two forensic experts	Person
Zimbabwe	Not stated	Not stated

[1] A country or territory is included only when the full text of the legislation has been reviewed and summarized in section A2.2 of Annex 2.

12.4 Length of treatment and periodic review

The length of treatment is specified in the legislation of countries and territories with legislation on treatment associated with the criminal justice system; it varies from a few days to an indefinite period. Provision for periodic review is also contained in the legislation of jurisdictions. The frequency of review varies, as does the body conducting the review. As stated in the 1987 WHO guidelines (Curran, Arif, Jayasuriya, 1987) legislation concerning treatment associated with the criminal justice system should declare it to be public policy to respect the rights of persons treated for alcohol or drug dependence and should establish mechanisms for the protection of such

rights (see Chapter 14 - Individual rights and responsibilities). For example, as stated in the 1986 WHO survey publication (Porter, Arif, Curran, 1986) the length of any period of involuntary confinement for the purpose of treatment should not exceed that needed for the treatment; and prescribed for the violation of the criminal law committed by the person being diverted to treatment.

In Afghanistan, Hong Kong, Israel, Philippines, Portugal, and Venezuela, and the United States of America (Massachusetts), the review is conducted at specified intervals (e.g. in Hong Kong, interviewed during the second month after admission, at least once every 2 months during the 4 months from the first interview, then once a month; and in Venezuela, under the Organic Law Governing Narcotic and Psychotropic Substances, periodic reports are made by specialists appointed by the judge). In Colombia, under Law 30 of 1986, where the length of stay may be the time required for recovery, the treating doctor must periodically inform the authorities of the state of health and rehabilitation of the drug addict. In Zimbabwe, under the Inebriates Act, when a magistrates court sentences a person to detention in an inebriate reformatory, the court must forward the proceedings, for review by a judge, under the provisions of the Magistrates Court Act.

The various provisions in the legislation summarized in Annex 2, section A.2.2, are shown in Table 13.

Table 13

Length of stay, frequency of review and by whom conducted, and initiator of review associated with the criminal justice system

Country or territory	Length of stay in treatment	Frequency of review and by whom conducted	Initiator of review
Afghanistan	Not more than two years	Concerned health organization is obliged to report to the respective court through the office of the prosecutor every 15 days on the health condition of the addict sentenced to detention	Concerned health organization
Argentina	Indefinite, but may not exceed the duration of the sentence. Treatment must be carried out first and counted as part of the time to be served	Not stated	Not stated
Bahrain	Until committee created by a decision of the Minister of Health decides on his release from the hospital, subtracting the period of confinement from the term of the sentence	Committee created by Minister of Health	Minister of Health

Table 13 *(continued)*

Country or territory	Length of stay in treatment	Frequency of review and by whom conducted	Initiator of review
Bolivia	Indefinite, until such time as certainty regarding their rehabilitation has been established	To determine certainty of rehabilitation	Not stated
Brazil	Not stated	When an offender has been rehabilitated, the judge must hear official expert testimony to that effect and the opinion of the public prosecutor and then decide whether to close the proceedings	Not stated
Chile	Not stated	Not stated	Not stated
China (Hong Kong)	Not less than two and not more than 12 months	Board of Review established for each treatment centre reviews the progress of each person since admission and makes recommendations relating to his release; persons must be interviewed: (*a*) during the second month after the date of their admission; (*b*) at least once every two months during the four months foll-owing the first interview; and (*c*) thereafter at least once a month	Chairman, Board of Review

Table 13 *(continued)*

Country or territory	Length of stay in treatment	Frequency of review and by whom conducted	Initiator of review
Colombia	Indefinite, time required for recovery	The treating doctor shall periodically inform the authority concerned with the case of the state of health and rehabilitation of the drug addict	Not stated
Egypt	Not less than six months nor more than three years, or the term of sentence, whichever is less	Not stated	Not stated
France	Not stated	Health authority follows the progress of the treatment and at regular intervals informs prosecutor of medical and social situation of the person; alternatively, physician responsible for treatment may propose that conditions of treatment be modified or the person be transferred to more appropriate facility	Health authority or physician responsible for treatment

Table 13 *(continued)*

Country or territory	Length of stay in treatment	Frequency of review and by whom conducted	Initiator of review
Germany	At least three months	Convicted person must prove he has started treatment or is continuing it	Persons treating a person, or institutions concerned must inform the law enforcement authority if treatment has been discontinued
Iran (Islamic Republic of)	Until rid of their addiction	Not stated	Not stated
Ireland	Not more than eight days	Court shall not permit a person to remain in a specified hospital, clinic or other place except in consideration of report of a medical practitioner or other person in charge of the hospital, clinic, or custodial treatment centre	Not stated

Table 13 *(continued)*

Country or territory	Length of stay in treatment	Frequency of review and by whom conducted	Initiator of review
Israel	Not exceeding three years or the term that the sentenced person has to undergo, whichever is the longer. Period of detention deducted from the term of imprisonment unless the court directs that the whole or part of that period may not be deducted. Where the court so directs, it must, after hearing the opinion of a psychiatrist (or a physician), determine whether the period of treatment in a closed institution shall take place before or after the person serves his prison sentence	Attorney General once every six months, brings the case before the court which may rescind the order if satisfied that there is no justification for continued detention in a closed institution	Attorney General
Italy	Not stated	Judge must revoke suspension and order resumption of measures when person has not cooperated or refused programme or has interrupted treatment	Not stated

Table 13 *(continued)*

Country or territory	Length of stay in treatment	Frequency of review and by whom conducted	Initiator of review
Jordan	Period determined by the commission authorized to examine those placed in sanatoriums	According to the programme and frequency as determined by the psychiatrist or social specialist in that clinic	Not stated
Malaysia	Six months, subject to extension at discretion of Board of Visitors of the rehabilitation centre for a period of not more than six months	Not stated	Not stated
Mauritius	Not exceeding 5 years	Not stated	Not stated
Philippines	Not stated	Director of the treatment centre must submit a written report to the court every four months or as often as the court requires on the patient's progress in treatment; at any time for voluntary patients	Director of the treatment centre for persons under confinement; for voluntary patients, person or parents or guardian
Poland	Not longer than 2 years	Court, on the basis of the results of treatment	Not stated.

Table 13 *(continued)*

Country or territory	Length of stay in treatment	Frequency of review and by whom conducted	Initiator of review
Portugal	Period necessary for recovery	After receiving the information, the court must decide on the continuation, modification or end of the measures it has ordered	Center for Drug Prophylaxy or the institution in charge of treatment must report every three months to the court on the gradual development of the patient. Centre may suggest equitable measures, including the end of the prescribed treatment, or its replacement by any form of voluntary treatment.
Qatar	Not less than three months and not more than one year	Not stated	Not stated
Spain (Federal)	Not stated	Judge or court remits sentence when period of suspension concluded and detoxification of the offender demonstrated	Duly accredited or authorized establishment or department certifies offender has been detoxificated
Trinidad and Tobago	Not more than 14 days	Court must rescind the order upon receipt of request from hospital director	Psychiatric hospital director must, when he is satisfied that the patient is no longer in need of care and treatment, report this fact to the court

Table 13 *(continued)*

Country or territory	Length of stay in treatment	Frequency of review and by whom conducted	Initiator of review
Turkey	Until fully cured	Not stated	Not stated
United Arab Emirates	Not less than six months and not more than three years	Committee supervising treatment in sanitarium submits to court once every six months, at most, a report on the condition of the comm-itted person. The court may, after having obtained the opinion of the Public Prosecutor, order his release from the sanatorium if the report indicates that his con-dition so permits; alter-natively, court may order release at the person's request with the approval of the comm-ittee and after obtaining the opinion of the Public Prosecutor; if request is rejected, it may not be renewed until six months has elapsed	Committee supervising treatment in sanitarium
United Kingdom	Not less than six months and not more than three years	Periodically at intervals not less than one month	Court responsible for the treatment and testing order
United States of America (Federal)	Six months, plus up to three years of post-hospital rehabilitation	After confinement for three months, person may petition court, which must inquire into health and general conditions of patient and need for continuing confinement	Person

Table 13 *(continued)*

Country or territory	Length of stay in treatment	Frequency of review and by whom conducted	Initiator of review
United States of America (Connecticut) Sections 17a-648 to 17a-658 of Chapter 329 General Statutes of Connecticut			
(*a*) Suspension of prosecution, and treatment for alcohol or drug dependency:	(*a*) Not more than 2 years	(*a*) Court, on own motion, or by person discharged from treatment may dismiss charge	(*a*) Office or Administrative Probation. Under Section 17a-654, at any time before the end of the period of suspension of prosecution, the office of adult probation may recommend to the court that the charge be dismissed if the person has (1) completed the treatment programme, (2) complied with all specified statutory conditions; and (3) abstained from the use of alcohol for one year if such person was alcohol-dependent or abstained from the unlawful use of drugs for one year if such person was drug- dependent).

Table 13 *(continued)*

Country or territory	Length of stay in treatment	Frequency of review and by whom conducted	Initiator of review
(*b*) Treatment for convicted drug- or alcohol-dependent person	(*b*) Not stated	(*b*) Court may require that a probation officer have at least one contact per week with the treatment programme in which the person is participating. Court must conduct hearing and may modify the sentence or terms of probation or terminate the probation and release the person.	(*b*) Director of treatment programme submits report to Office of Adult Supervision that person has completed the treatment programme and the court is notified
United States of America (Massachusetts)	Not more than 18 months or period of time equal to maximum sentence person could have received, whichever is shorter.	Quarterly written reports on progress of treatment	Administrator of treatment facility
Venezuela	For occasional users, Judge must order release and place under specialist care for period indicated by specialists	On the basis of the report from specialists, the Judge must order continuation or suspension of the action	Specialists appointed by judge shall periodically inform the Judge of the state of the suspect.
Zimbabwe	Not more than three years	Not stated	Not stated

13. Compulsory and voluntary reporting, central registries, laboratory testing and community surveillance

Legislative provisions requiring the reporting, central registration, laboratory testing, and community surveillance of drug- or alcohol-dependent persons were found in over half (35 of 80) the countries and territories surveyed.

13.1 Compulsory and voluntary reporting

Provisions governing reporting were found in 32 of the 80 countries and territories in the present survey. In general, they require certain individuals or organizations to notify government officials of persons known or suspected to be drug-dependent. A few countries also have reporting requirements for alcohol dependence. The persons or organizations required to make such reports vary widely and include law-enforcement officials, public prosecutors, hospitals, clinics, parents, prison authorities, public authorities, and medical practitioners. Physicians and other medical personnel who first contact drug-dependent persons are most often specifically identified in the legislation and required to report to the health or other authorities any drug- or alcohol-dependent person that they encounter. As emphasized in the 1986 WHO study on this subject (Porter, Arif & Curran, 1986), the criteria specified in the legislation for physicians to initiate the reporting process are of special interest, because a reporting requirement places the physician in the position of having to choose between protecting confidentiality and meeting the legislative requirements. Failure to report may make the physician liable to fines and/or imprisonment under the laws of many countries. Since a drug-dependent person will be aware that the physician is obliged to report him to the authorities, he may choose not to seek any medical care at all or turn to unqualified practitioners. An example of such a requirement is found in the legislation of Malta where, under the provisions of the Drugs (Registration of Addicts) Regulations, 1986, it is the duty of every practitioner to report every addict under his care, who in his opinion is suffering from any form of addiction to or dependence on, a drug. Moreover, a register of addicts must be kept in which are entered the name and other prescribed information set out in schedules of every patient who is a drug addict. No practitioner may prescribe any drug to any such patient unless the practitioner has made the required report.

In the United States of America, Federal legislation (and implementing regulations, promulgated by the Federal Department of Health and Human Services) protects the confidentiality of patient records of drug- and alcohol-dependent patients. The Federal alcohol and drug abuse confidentiality statutes (42 United States Code 4582, 21 United States Code1175) and regulations (42 Code of Federal Regulations

Part 2) apply, to keep confidential records of the identity, diagnosis, prognosis, or treatment of any drug- and alcohol-dependent patient.

The agencies to be notified vary, but can be grouped into two broad categories: (*a*) administrative and law-enforcement agencies; (*b*) ministries of health or social welfare. The agency prescribed will reflect the purpose of the legislation, which is designed predominantly for drug-control rather than treatment purposes. The content of the notification is clearly intended for use in individual record-keeping and for other administrative purposes.

Table 14 lists the countries and territories having such legislation, but covers only those provisions relating to civil commitment or treatment associated with the criminal justice system. For some countries, such requirements are contained in more than one category of legislation. Under the heading of laboratory testing, the provisions are concerned primarily with law enforcement, e.g. urine tests for use in screening. Surveillance provisions cover post-correction after-care requirements; community observation for health problems associated with alcoholism; and social system needs. The relevant legislative provisions are summarized in Annex 2.

Table 14

Countries or territories with legislation on case reporting, central registries, laboratory testing and community surveillance

Requirement	Countries or territories
Compulsory and voluntary notification	Afghanistan, Bangladesh, Belize, Colombia, China (Hong Kong), Czech Republic, Finland, France, Hungary, Israel, Italy, Kenya, Malaysia, Malta, Mauritius, Mexico, Myanmar, Paraguay, Philippines, Portugal, Spain, Sri Lanka, Switzerland
Central registries	Afghanistan, Bangladesh, Colombia, China (Hong Kong), Czech Republic, Finland, France, Italy, Kenya, Malta, Myanmar, Papua New Guinea, Portugal, Sri Lanka
Laboratory testing	Bangladesh, China (Hong Kong), Greece, Myanmar, Paraguay, Philippines, Poland, Seychelles, United Kingdom
Community surveillance	Afghanistan, China (Hong Kong), Finland, Hungary, Israel, Italy, Malaysia, Mexico

13.2 Central Registries

Registration of drug-dependent persons is required for a number of different purposes, as spelled out in the legislation. As noted the 1986 WHO study (Porter, Arif, Curran, 1986) central registries can be helpful to persons who have been arrested and who may seek diversion from the criminal justice system because of drug or alcohol dependence. If their names are on the register, they can prove that they have a substance dependence and have sought treatment. A member of the Harvard Advisory Group, Dr Robin Room noted (R.Room, unpublished personal communication, 1996) that while the main emphasis in most general discussions of central registries is on the loss of privacy and opening for discrimination such registries provide, in the broader field of medical, psychiatric and welfare records, central registries have been abandoned in many places because of the potential infringements on individual rights they facilitate. For example, in Russia, it was seen as a great step forward when narcology treatment was first offered on an anonymous basis in the late 1980s. There is a cultural divide between different societies. An example of a registry system that is considered a success is the Central Registry of Drug Abuse in China (Hong Kong Special Administrative Region), which has five objectives (Hong Kong, 1994): (i) to identify and forecast trends in the nature of addiction and the addict population in Hong Kong with reference to the demographic characteristics of the overall population; (ii) to coordinate statistics from various sources for the purpose of analysing the characteristics of the reported addict population at any given time, and to contrast these characteristics with those of abusers as reported from various sources; (iii) to provide statistics to facilitate the evaluation of the effectiveness of various treatment and rehabilitation programmes; (iv) to provide a database which is responsive to requests for monitoring selected groups of drug abusers with regard to their drug abusing patterns over a given period of time for research purposes; and (v) to provide a basis for integrating with other drug-related statistical systems so that information in these systems can be captured and various statistics related and compared.

Members of the Harvard Advisory Group noted that diversion from the criminal justice system to treatment can be aided by a central registry that indicates that the offender is currently undergoing treatment[1]. The Group also observed that the crucial question for registries is often that of patient confidentiality. Inappropriate use of information by the criminal justice system is to be feared, and information reported to, and contained in, registries must remain confidential except for the limited purposes and exceptions specified and recognized in the law of the country concerned. As emphasized in the 1987 guidelines (Curran, Arif & Jayasuriya, 1987), if confidentiality is not maintained, there will be resistance to such reporting, thus defeating the purposes

[1] Participants at the Harvard Advisory Group meeting addressed central registries, compulsory and voluntary reporting, and the coordination of public health and law- enforcement objectives and this paragraph states the main elements of a paper presented at the meeting by Dr James Chi'en (Chi'en, unpublished observations, 1994).

of the register. Central registers infrequently serve a valuable role in relapse studies but, in general, the care-giving community is uncomfortable about such efforts. In addition, central registries can potentially play an important role in improving client care. Regrettably, however, social work case registries were abandoned in the United States when research revealed that most agencies ignored the fact that a client was served by other agencies. In China (Hong Kong Special Administrative Region), the central registry of drug abusers is maintained by the drug policy authorities. As noted by the Government of Hong Kong (Hong Kong, 1994), the network of reporting agencies provides information to the Central Registry of Drug Abuse (CRDA) on a voluntary basis, which requires the cooperation of both individual drug-abusers and reporting agencies. The records of all persons reported to CRDA are kept confidential. Legislative protection for confidentiality is provided under the Dangerous Drugs (Amendment) Ordinance, 1981, which provides immunity from search and from production in court, except under specified serious and compelling circumstances. Data in the Registry are accessible only to those directly involved in its operation, who are required to observe the prohibition of disclosure imposed by the Ordinance. As noted by the Government of China (Hong Kong Special Administrative Region) (Hong Kong, 1994), this statutory protection helps to ensure cooperation with reporting agencies and eases the fears of drug-dependent persons that they will be exposed when they seek treatment. The limitations of drug-abuse statistics are recognized by the Hong Kong Government, namely that reporting is carried out by reporting agencies on a voluntary basis and the registry can record only those persons who have come into contact with those agencies. The Hong Kong experience provides useful guidance on reporting and the coordination of public health and law-enforcement objectives. It was reported (Chi'en, unpublished observations, 1994) at the Harvard meeting that Hong Kong established a computerized database in 1976 with a standardized semi-annual reporting system. This has helped to identify a long-term decline in the prevalence rates of drug abuse in relation to the increase in the general population. Participation in the system has expanded gradually over the years to encompass most of the health and welfare community, with the exception of physicians in private practice, who are willing to submit periodically only statistical reports on substance-abuse cases receiving treatment. In the Hong Kong Special Administrative Region, the Dangerous Drugs (Amendment) Regulation 1996 amended several provisions of the Dangerous Drugs Regulations of 12 November 1968; those concern: requirements with regard to the information to be included in prescriptions for dangerous drugs and in registers and other resources[2]. Treatment and rehabilitation are comprehensive and extensive, and are provided both by the Government and by nongovernmental organizations. Self-help and mutual-assistance groups are also widespread (see the discussion of self-help

[2] The Government of Hong Kong Special Administrative Region Narcotics Division reports (Hong Kong, 1999b) that during 1996, 1997, 1998, the Action Committee Against Narcotics recommended amendments to the Dangerous Drugs Regulations to "tighten record-keeping requirements by requiring the entering in the Dangerous Drugs Register of the identity card number of the patient to whom dangerous drugs are supplied so as to minimize illegal supply of dangerous drugs by unscrupulous doctors".

groups in Chapter 4). In Pakistan, the Control of Narcotic Substances Ordinance, 1996, requires the Federal Government and each Provincial Government to register "all addicts within their respective jurisdiction for the purpose of treatment and rehabilitation of addicts"; and the addict is required to carry a registration card and produce it, on demand, to proper authority. The Ordinance provides also that the Federal Government and the Provincial Governments will pay all expenses for first-time compulsory detoxification, or, "de-addiction" of an addict.

Registries are kept of persons dependent on alcohol as well as on other drugs. For example, under the provisions of the Law of 28 March 1989 of the Czech Republic on the Protection Against Alcoholism and Other Toxicomania, the health service establishment registers persons dependent on alcohol or another habit-forming drug.

In some jurisdictions, persons seeking lawful government distribution of opium or other substances under a treatment programme are required to register with the government. Under the Narcotic Drugs and Psychotropic Substances Law of Myanmar, a drug-user must register at the place prescribed by the Ministry of Health or at a medical centre recognized by the Government for this purpose for medical treatment. The Ministry of Health is required to establish and carry out such medical treatment programmes as may be necessary for a registered drug-user, who must abide by the directives issued by the Ministry. Under this Law, a drug-user who fails to register at the place prescribed by the Ministry of Health or at a medical centre recognized by the Government for this purpose or who fails to abide by the directives issued by the Ministry of Health for medical treatment must be punished with imprisonment for a term which may extend from a minimum of three years to a maximum of five years. Registration may also be required of regional governments as part of their social and welfare functions, in facilities which are empowered by the Government to deliver treatment or rehabilitation services. In Italy, under the provisions of Law No. 162 of 26 June 1990, regional governments and the autonomous provinces must create a register of the agencies (e.g. non-profit-making voluntary bodies, ancillary agencies) which manage facilities for the rehabilitation of drug addicts.

As noted in the 1987 WHO Guidelines (Curran, Arif & Jayasuriya, 1987), no studies seem to have been carried out to determine the effectiveness of registers of dependent persons, but they would seem to have obvious advantages, provided that physicians, public health officers and law-enforcement agencies comply fully with the requirement to report all cases of dependence, otherwise the information will be biased and of little use for epidemiological or programme evaluation purpose. On the other hand, as has already been pointed out, if confidentiality is not maintained, there will be resistance to such reporting, and the purpose of the register will be defeated.

Information on reporting requirements is summarized in Table 15.

Table 15

Reporting requirements

Country or territory	By whom made and basis for notification	Agency notified	Content of notification
Afghanistan	Concerned health organization must report for addicts sentenced to detention	Court concerned (i.e. court that made final decision) through the office of the prosecutor, every 15 days	Health condition of drug addict sentenced to detention
Bangladesh	(*a*) The head or any other adult person of the family, if member of a family has become addicted to narcotics	(*a*) Director General (i.e. person appointed under the Act) or any officer subordinate to him	(*a*) Fact of narcotics addiction
	(*b*) Physician if it appears that the person under his treatment is addicted to narcotics and requires treatment	(*b*) Physician must advise the addicted person about such treatment and must also inform the Director General in writing regarding the necessity of such treatment	(*b*) Fact of narcotics addiction, which requires treatment
Belize	Medical practitioner with reasonable grounds to suspect person is addicted, to report such person	Prescribed authority	Such particulars with respect to that person as may be prescribed in regulations

Table 15 *(continued)*

Country or territory	By whom made and basis for notification	Agency notified	Content of notification
China (Hong Kong)	Confidentially and on a voluntary basis, each of 34 reporting agencies (law-enforcement agencies, and welfare organizations) when they come in contact with known or suspected drug abusers	Central Registry of Drug Abuse	Confidential information recorded by the Registry: data on drug-abuser's contact with reporting agency, name, identity card number, date of birth and sex of drug abuser, social characteristics (schooling, employment), primary and secondary drug use, and age when first used
Finland	National Control Register for the Control of Narcotics	National Board of Health	Compilation of information in accordance with Narcotics Law of 21 January 1972 and the Narcotics Ordinance of 15 April 1981
France	Public Prosecutor who has ordered a person to undergo detoxification or to submit to medical surveillance	Competent health authority	Fact that prosecutor's order has been made

Table 15 *(continued)*

Country or territory	By whom made and basis for notification	Agency notified	Content of notification
Hungary	Purpose of report of director of institution is to permit the health agency to arrange for surveillance or after-care of alcoholics who have undergone institutionalized care	Health agency in place of residence	Director of institution must notify health agency in the place of residence of the institutionalized person regarding temporary leave or final discharge
Israel	Officer in charge of closed institution for treatment of drug-addicted persons sentenced to imprisonment	Officer in charge must immediately notify Attorney General of the hospitalization or release of any patient, and must also notify the district attorney of the district in which the court that made the order is situated, or, if the order was made by the Supreme Court, the State Attorney	Officer in charge must prepare monthly report on the treatment and condition of the patient and the prospects of his recovery and must recommend the continuance or discontinuance of his treatment
Japan	Medical practitioners; narcotic control officers; public prosecutor; chief of correctional institution	Governor of Metropolis, Hokkaido or Prefecture	Name, domicile, age, sex and other matters (as applicable)

Table 15 *(continued)*

Country or territory	By whom made and basis for notification	Agency notified	Content of notification
Kenya	Information must be given by the person in charge, when the person received into a mental hospital as an involuntary patient under the section of the Act pertaining to involuntary patients, or if a patient so received dies in, or departs from, the mental hospital,	District mental health council	Information of the reception, death or departure of person received into a mental hospital
Malaysia	Registered medical practitioner, including government medical officers, of treatment given to drug-dependent person	Director General appointed under Drug Dependents Act 283, 1983.	Person who is treated for drug dependency in accordance with rules made under this Act
Malta	Every practitioner of every patient under his care	Superintendent, on a prescribed form	Patient who in practitioner's opinion is suffering from any form of addiction to or dependence on a drug

Table 15 *(continued)*

Country or territory	By whom made and basis for notification	Agency notified	Content of notification
Mauritius	Every person supplying dangerous drugs must report any discrepancy found to exist as result of check on stock of dangerous drugs	Permanent Secretary	Check stock of dangerous drugs and balance each register
Mexico	Any person, concerning: (*a*) raw materials used in industry, separately or in combination, which produce or may produce psychotropic effects when inhaled; (*b*) end-products containing organic solvents, which produce or may produce psychotropic effects when inhaled	Ministry of Health and Welfare	Any violations of these regulations by organizations or individuals trading illegally in inhalable substances with psychotropic effects, and information about the meeting places of inhalers
Myanmar	Drug-users must register in accordance with stipulations	Places prescribed by Ministry of Health or a medical centre recognized by Government for medical treatment	Fact of drug use

Table 15 *(continued)*

Country or territory	By whom made and basis for notification	Agency notified	Content of notification
Paraguay	(*a*) Relevant court must communicate to National Department of Narcotics (DINAR) (*b*) Armed and police forces	National Department of Narcotics (DINAR) must maintain statistics on the persons tried, detained and convicted for the offences provided for in this Law	(*a*) Relevant court: information on proceedings, detentions, convictions and releases ordered; (*b*) Armed and police forces, other public and private institutions must inform DINAR. Armed and police forces, whenever they intervene in, or become aware of, cases of the kind contemplated in this Law
Philippines	Court at any stage of criminal proceedings finds person to be drug-dependent	Dangerous Drug Board	Judicial and medical records pertaining to any drug-dependent's confinement or commitment
Portugal	All public prosecutors	Criminal Police	All decisions issued in accordance with Decree 430/83

Table 15 *(continued)*

Country or territory	By whom made and basis for notification	Agency notified	Content of notification
Spain (Federal)	(*a*) Health professional (*b*) Health professionals prescribing treatment with methadone shall notify the said officials quarterly of the progress of the therapy. All such data shall remain confidential	The competent health officials	(*a*) A plan of treatment (*b*) The methadone treatment plan for persons dependent on opiates shall include: (i) assessment of physical, mental, family, occupational, and social position of patient at the beginning of treatment; (ii) information on the nature and dosages of toxic substances taken at the beginning of the process leading to drug dependence, circumstances in which the process began, the development of drug dependence, and quantity of heroin used at the time when treatment was begun; (iii) guidelines on the medical care provided with a check on the physical condition, nutritional state, and infectious diseases; (iv) analyses to assess the detoxification of the patient; (v) all medical and nursing care appropriate and necessary to the treatment of the patient.

Table 15 *(continued)*

Country or territory	By whom made and basis for notification	Agency notified	Content of notification
Sri Lanka	Director of Health Services, who may in his discretion distribute raw or prepared opium to registered consumers or registered ayurvedic practitioners as provided for in the Act	Distribution made through opium officers who are public officers in the Department of Health specially appointed by the Director to be opium officers; and officers in charge of all hospitals and dispensaries of the Department of Ayurveda appointed by the Commissioner for Ayurveda to be opium officers	Fact of status as drug consumer or Ayurvedic practitioner
Switzerland	Administrative services, physicians, and pharmacists where they consider that protective measures are indicated in the interests of the patient, his close associates or the community	Competent supervisory authority or an approved treatment or care institution	Cases of narcotic abuse detected in conduct of official or professional activities

13.3 Laboratory testing

In Bangladesh, under the Narcotic Drugs and Psychotropic Substances Control Act, 1990, while making any investigation or search under this Act, any officer who has reason to believe that any person has concealed any narcotics in any part of his body may, after recording the grounds for such belief, order the person to submit himself for X-ray or any other examination including urine examination, and if such person refuses to comply with the order, the officer passing the order may take any measure including use of force to compel the person to comply with the order. In the Czech Republic, under the Law of 28 March 1989 on the Protection Against

Alcoholism and Other Drugs, a person who is acting in such a way as to threaten people's life or health, or damage property is not authorized to take alcoholic drinks or other habit-forming drugs when performing this activity or before its performance if he may still be under their influence during the activity. The person acting in a dangerous way must undergo a test to detect the presence of alcohol or other habit-forming drugs. The alcohol test is in two parts: (1) a breath test and, if a positive result is obtained, (2) blood analysis. The presence of habit-forming drugs is detected by the analysis of urine, saliva, or blood. In Greece, tests to determine whether narcotics have been used, consist of a laboratory verification (toxicological analysis of body fluids) and a clinical examination (supplementary detailed examination); these must be carried out in accordance with Ministry decision No. a2b/ik 3984 of 7 October 1987, which establishes the conditions applicable to the pharmacological test for this syndrome of withdrawal from drugs. Pharmacological tests for this syndrome are authorized in the following cases: (1) the life of the person is at risk, or there is a risk of serious harm to health or of significant complications in a disease from which he is suffering; (2) the test is indispensable for carrying out diagnostic or therapeutic procedures, for the emergency transport of the person concerned, or if the indications of the syndrome preclude treatment for a disease; (3) the person in question is pregnant; and (4) the test is indispensable because of other acute symptoms displayed by the person concerned, provided that he is subsequently transferred to a special therapeutic centre for detoxification. Provisions are also made in this decision in respect of the methods for carrying out the pharmacological tests for the syndrome and the procedures for the test.

In the Philippines, the Dangerous Drug Act of 30 March 1972, as amended on 2 March 1982, provides that any person apprehended or arrested under the Act must, immediately upon his arrest or apprehension, be subjected to laboratory examination or tests, if the apprehending or arresting officer has reasonable ground to believe that the person arrested or apprehended (on account of physical signs or symptoms or other visible or outward manifestation) is under the influence of dangerous drugs. If the tests are positive for such drugs, the results of the laboratory examination test will be *prima facie* evidence that such person has used dangerous drugs. If found negative, the person must be released, immediately, unless there is other evidence indicative of such violation. For this purpose, the Philippines Dangerous Drug Board must establish, operate and maintain drug-testing centres in each province and city in order to conduct the laboratory examination tests provided for in the Act, and appoint such technical and other personnel as may be necessary for the effective implementation of its provisions.

In Seychelles, a police officer in charge of a police station, or a police officer not below the rank of Superintendent may, if he reasonably suspects that a person has committed an offence under the Misuse of Drugs Act, 1990, require the person within such time as may be specified by him to provide a specimen of his urine or blood for a test. In the United States of America (Massachusetts), under the Drug and Rehabilitation Law of 24 December 1981, any court may, in placing a defendant who is a drug-dependent person who would benefit by treatment, make it a condition of probation that the defendant receives treatment in a facility as an inpatient or outpatient. Periodic urinalysis to confirm the drug-free status of the probationer may be made a condition of probation.

In the United Kingdom, under the Crime and Disorder Act 1998 (c.37), for the purpose of ascertaining whether an offender has any drug in his body during the treatment and testing period, the offender must provide during that period, as in such other circumstances as determined by the treatment provider, "samples of such disruption as may be so determined".

13.4 Community surveillance

Community surveillance or supervision is an important part of the continuum of treatment and rehabilitation services in many jurisdictions. Surveillance or supervision of a drug- or alcohol-dependent person may be pursuant to probation, parole, or an after-care order. Testing for drug-free status may be required; failure to adhere to after-care orders may result in involuntary return to confinement. Community surveillance may be observational in nature, as an adjunct to social services, together with medical services, such as methadone maintenance programmes or other harm-reduction strategies. Community surveillance may be in lieu of compulsory detoxification services.

Community surveillance is often characterized by the following: (1) an order by the court or other decision-making body designated in the legislation; (2) a limited duration, subject to sanctions for failure to comply; and (3) periodic urinalysis or other testing to determine drug-free status during the after-care and surveillance period. It may be part of an after-care programme following compulsory civil commitment or treatment associated with the criminal justice system, under probation, parole, or an after-care order. Community surveillance has several features which make it attractive to policy-makers and legislators: (1) it should cost less than institutional confinement; (2) it has the potential, through the involvement of community resources for the general population to "get involved" in supporting needed activities, financially and through the efforts of nongovernmental organizations; (3) political leaders and government agencies are able to rely on the reaction of the community at large for feed-back so that necessary modifications to surveillance programmes can be made.

In China Hong Kong Special Administrative Region, the Drug Addiction Treatment Centres Ordinance, Revised Edition 1988 (Ordinance No. 42 of 1968) provides that the Commissioner of Correctional Services may order that a person released from an addiction-treatment centre be subject to supervision, for 12 months after release, by such organization or person as the Commissioner of Correctional Services may specify. The person must then comply with such requirements in respect of medical examination and residence as may be specified by the Commissioner of Correctional Services, who may at any time vary or cancel a supervision order. Similarly, in Malaysia, under the Drug Dependents (Treatment and Rehabilitation) Act, 1983, a person undergoing after-care may be required by a treatment centre Board of Visitors to comply with such conditions as the Board of Visitors may specify in an

after-care order, including residence in an After-care Centre for a period not exceeding six months for such hours each day or otherwise as may be specified in such after-care order. In several countries (Finland, France, Senegal), the legislation permits the authorities to order persons in need of treatment to be placed under medical surveillance in lieu of compulsory detoxification. In France, subsidiary legislation (Circular DGS-DH No. 15 of 7 March 1994) provides for the involvement of hospital departments in the management of drug addicts, with at least 3- beds to be reserved for detoxification, and for the development of municipal/hospital drug-addiction networks involving general practitioners, hospitals, specialized treatment centres and, where applicable, social services and other professionals involved. In several jurisdictions (e.g. Sweden, United States of America), specialized community surveillance legislation has been enacted for minor children. In the United States of America (Florida) (Chapter 397, Section X, 397.901), the Florida Department of Health and Rehabilitation Services must designate and initiate prototype juvenile addictions-receiving facilities in geographical areas where the substance-abuse impairment crisis places juveniles and their families at the greatest risk because of an unfavourable combination of social, environmental, and economic conditions, including such factors as poverty, a high crime rate, a high incidence of substance-abuse impairment, and a high drop-out rate. Prototype juvenile addictions-receiving facilities may be designated to provide substance-abuse-impairment treatment services and community-based detoxification, stabilization, and short-term treatment and medical care to juveniles found to be impaired, in need of emergency treatment as a consequence of being impaired, or incapable of making an informed decision about their need for care. In Sweden, the Care of Young Persons (Special Provisions) Act (SFS 1990:52) of 8 March 1990 provides that a care order must be made if, due to physical abuse, exploitation, deficiencies of care or some other circumstances in the home, there is a palpable risk of a young person's health or development being impaired. A care order is also to be made if a young person exposes his health or development to a palpable risk of injury through the abuse of addictive substances, criminal activity or some other socially degrading behaviour. Orders for placing young persons under care pursuant to this Act are issued by the county administrative court of appeal at the instance of the social welfare committee.

14. Individual rights and responsibilities

14.1 General

Drug and alcohol programmes will fail without the active and willing participation of the patient who takes responsibility and actions for fully participating and staying in treatment, and in rehabilitation. Patient responsibility and its individual and societal benefits should be emphasized in drug and alcohol policies, legislation and programmes.

Protection of patients' personal rights is especially important also because of the deprivation of liberty involved in both civil and criminal treatment systems. A balance must be found between state powers to detain persons involuntarily for public health and safety reasons and the personal rights of individuals while detained for treatment or rehabilitation.

The WHO Expert Committee on Drug Dependence reviewed the subject of human rights at its twenty-eighth meeting (World Health Organization, 1993c), and recommended that:

> WHO should review 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.

Participants in the WHO Advisory Group meeting at Harvard University also emphasized the importance of human rights issues; and that essentially all of the concerns of the WHO Expert Committee on Drug Dependence, referred to previously, are relevant to this study.

Human rights issues seem to receive little or low priority currently at the international level[1]. In particular, the United Nations Drug Control Programme made no formal submission to the World Conference on Human Rights in 1994. It is beyond the scope of this study to provide a comprehensive survey of protection accorded in international law to human rights. Some United Nations instruments expressly provide for the protection of drug- or alcohol-dependent persons. For example, the United

[1] Participants at the Harvard Advisory Group meeting addressed the human rights issues in drug and alcohol treatment and rehabilitation, and this paragraph states the principal elements of a paper presented by Mr Sev Fluss (S. Fluss, unpublished observations, 1994).

Nations General Assembly, in December 1990, adopted Rules for the Protection of Juveniles Deprived of their Liberty (United Nations, 1990b). These Rules provide that juveniles deprived of their liberty have the right to facilities and services that meet all the requirements of health and human dignity; that juvenile detention facilities should provide specialized drug-abuse prevention and rehabilitation programmes administered by qualified personnel, and such programmes should be adapted to the age, sex and other requirements of the juveniles concerned, and detoxification facilities and services staffed by trained personnel should be available to drug- or alcohol-dependent juveniles. Under the Rules, every juvenile should have the right to talk in confidence to any inspecting officer.

Because civil commitment, even in the least restrictive setting, is coercive and a deprivation of liberty, fundamental principles of human rights are at stake when governments order persons involuntarily to undergo treatment for drug or alcohol dependence. It is thus important not only to adopt policies and legislation to protect individuals during treatment, but also to promote their individual involvement and initiative to move through the treatment phase into a productive life in the community. Consequently, it is in the interest of both individuals and governments to have laws and effective practices that fulfil these purposes.

As more fully described in previous chapters of this study, as well as in the 1986 WHO study (Porter, Arif, Curran, 1986) and the 1987 WHO guidelines (Curran, Arif, & Jayasuriya, 1987) exemplary comprehensive legislative provisions designed specifically to protect the individual personal rights of drug- or alcohol-dependent persons would be special civil-commitment legislation on drug dependence, alcohol dependence, or combined approaches, that is consistent with the following: (1) the right to individual dignity of the patient; (2) the right to non-discriminatory services; (3) the right to treatment services appropriate to individual needs; (4) the right to communication with persons; (5) the right to custody of personal effects; (6) the right to confidentiality of records; (7) the right to counsel at all stages of proceedings; and (8) the right at a certain time to petition and appear before a court to question the legality of the detention.

With few exceptions, e.g., Chile, we found no comprehensive legislative provisions designed specifically to protect the individual personal rights ("patients rights") of drug- or alcohol-dependent persons. However, many jurisdictions seek to protect the individual personal rights of patients (e.g. to receive visitors, send and receive mail, and to receive effective treatment for their health problems) through the enactment of a variety of types of legislation, applicable generally to all patients, including those in drug- and alcohol-treatment settings. Some laws provide for an ombudsman or patients' rights representatives to address grievances and act as intermediaries between patients and officials in health facilities.

In Chile, Decree No. 2298 of 10 October 1995 [IDHL, 1998.49 (2)] adopts regulations on establishments that provide rehabilitation for persons dependent on

psychoactive substances, through community care. Under the "patients rights" sections, a person in treatment has the following rights:

(1) the right to an individual programme of rehabilitation and to be informed of the nature and content of that programme;
(2) the right to respect for privacy, including correspondence and personal effects;
(3) the right to leave treatment, unless a court order has been issued or unless a medical certificate is prescribed in which case detention may not be longer than 24 hours; and (4) the right to disagree with the rehabilitation programme and its implementation.

14.2 Individual rights

Many countries have enacted general legislation on patients' rights with no special reference to a particular disease, such as alcohol dependence, drug dependence or mental illness. An example of such general legislation is Law No. 482 of 1 July 1998 on Patients Rights, enacted in Denmark, applicable to patients who, within the health system or in other places in which health services are provided, receive or have received treatment from a health care provider [IDHL, 1999 *50* (1)]. While such legislation may apply to drug and alcohol dependent persons, a survey of all such general legislation is outside the scope of the present survey which focuses on drug and alcohol dependence.

14.2.1 *Protection of patients' rights under mental health codes*

Our legislative survey revealed a trend towards the development of patients' rights protection under national mental health laws; including those which expressly mention, or apply in practice to, drug or alcohol dependence. For example, the Law of 2 July 1992 of the Russian Federation on psychiatric care and the safeguarding of citizens' rights in the dispensing of such care, which applies expressly to the compulsory treatment of drug- and alcohol-dependent persons, proscribes the use of chemical or mechanical restraint, which should not be authorized except in extraordinary circumstances and then only with the written permission of the ministry concerned, the National Drug and Alcohol Control and Treatment Board, or the special review body. Moreover, chemical treatment for drugs or chemical maintenance should not be used without the consent of the person concerned except during emergency or detoxification treatment. In addition, drug- or alcohol-dependent patients, whether voluntary or committed, in residential institutions should be allowed to receive a reasonable number of visits by relatives and friends. Communication with lawyers, patient representatives or advocates, and with the courts and special relief panels or board, should be allowed at all times, and stationery, stamps, etc. provided. However, reasonable security measures are necessary in treatment centres including surveillance

to prevent the receipt of contraband drugs or alcohol, and weapons. The Law provides that, if the patient is mentally ill as well as drug- or alcohol-dependent, other appropriate measures may be taken to ensure his or her safety and that of the institution and the public in periods of serious mental disturbance. Those undergoing treatment of any type may be required, as a condition of continuing to receive such treatment, to comply with the prescribed treatment schedules, including rehabilitation and vocational training, and submit to surveillance measures, such as urine analysis and other means of detecting drugs or alcohol in the body.

At the international level, resolution 46/119 of the General Assembly of the United Nations, (United Nations, 1991) is designed for the protection of persons with mental illness and the improvement of mental health care. Under principle 4 of the resolution, determination that a person is mentally ill must be made in accordance with internationally accepted medical standards. While there are no separate provisions in resolution 46/119 relating specifically to drug or alcohol dependence, it is important, for the three reasons discussed below.

First, its provisions are concrete and address both substantive and procedural measures which are essential to the protection of persons dependent on drugs or alcohol. Resolution 46/119 covers the following subjects: fundamental freedoms and basic rights (e.g. respect for dignity, non-discrimination, right to counsel, etc.); protection of minors; confidentiality; right to treatment in the least restrictive environment, and by the least restrictive and intrusive method appropriate to the patient's health needs; medication administered solely for health needs and not for the convenience of others or as a management tool; and no treatment without informed consent. Every effort is to be made to avoid involuntary admission, and any such admission must initially be for short periods, and the patient's family and a review body must be informed as to the grounds for such admission. Review procedures by an impartial body, procedural safeguards and the right to make a complaint, are also included in the resolution.

Second, the content of resolution 46/119 is generally consistent with the direction of mental health law reforms and mental patients' rights legislation at the national and subnational level, and the problems of human rights in mental health law and in the law on substance abuse are essentially the same.

Third, should the General Assembly consider the adoption of a resolution on the protection of persons with drug or alcohol dependence, resolution 46/119 provides a useful model. The experience of the few (but significant) examples of national patients' rights legislation applicable to drug and alcohol dependence (discussed later in this Chapter) provides a good starting point for the assessment and revision of national codes.

14.2.2 *Specific national constitutional and statutory protection*

At least one jurisdiction (Hong Kong) has incorporated an international human rights code into special statutory legislation specifically designed to protect human rights, namely the Hong Kong Bill of Rights Ordinance 1991. This provides for the incorporation into the law of Hong Kong Special Administrative Region of the provisions of the International Covenant on Civil and Political Rights. At the present time, the Drug Addicts Treatment and Rehabilitation Ordinance (Chapter 326, of the Laws of Hong Kong) applies to drug treatment on a voluntary basis. Treatment associated with the criminal justice system is administered in Hong Kong Special Administrative Region under the provisions of the Drug Addiction Treatment Centres Ordinance (Chapter 244, Laws of Hong Kong). As previously noted in Chapter 6, the Joint Declaration of the Government of the United Kingdom of Great Britain and Ireland and the Government of the People's Republic of China on the Future of Hong Kong, dated 19 December 1984, provided that the Government of the United Kingdom restore the sovereignty of Hong Kong to the People's Republic of China on 1 July 1997.

On this date, the Basic Law of the Hong Kong Special Administrative Region of the People's Republic of China (Hong Kong, 1990), dated April 1990, came into effect. Under its terms laws previously in force in Hong Kong, including the common law, rules of equity, ordinances, subordinate legislation and customary law, must 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. There are no legislative or regulatory provisions pertaining specifically to the treatment of drug dependence or to rehabilitation in China.

Analysis of fundamental rights protection for individuals begins with an analysis of constitutional provisions. The constitutions of many countries contain provisions for a right to health. In this regard, reference should be made to a Pan American Health Organization publication on this subject (Fuenzalida-Puelma & Connor, 1989). In Sweden (Sweden, 1999b) protected by its constitution is the right to have deprivation of liberty tried by a court of law or an authority of equal rank, without due delay.

The Constitution of Zimbabwe, as amended on 1 August 1985, provides in Section 11 that every person in Zimbabwe is entitled to the fundamental rights and freedoms of the individual, namely the right whatever his race, tribe, place of origin, political opinion, colour, creed or sex, but subject to respect for the rights and freedoms of others and for the public interest, to each and all of the following: (*a*) life, liberty, security of the person and the protection of the law; (*b*) freedom of conscience, of expression and of assembly and association; and (*c*) protection for the privacy of his home and other property and from the compulsory acquisition of property without

compensation. However, deprivation of **personal** liberty is expressly permitted in the Constitution of Zimbabwe (Section 13, **Part III**), as follows:

> 13. (1) No person shall be deprived of his personal liberty save as may be authorized by law in any of the cases specified in subsection (2).
>
> (2) The cases referred to in subsection (1) are where a person is deprived of his personal liberty as may be authorized by law —
>
> ....
>
> (h) if he 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 protection of the community;

A similar provision exists in the Constitution of Zambia:

> 15. (1) No person shall be deprived of his personal liberty save as may be authorized by law in any of the following cases, that is to say:
>
> ....
>
> (h) in the case of a person who is, or is reasonably suspected to be, of unsound mind, addicted to drugs or alcohol, or a vagrant, for the purpose of his care or treatment or the protection of the community.

The 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987) urged that legislation should declare it to be public policy to respect the rights of persons treated for alcohol or drug dependence and should establish mechanisms from the protection of such rights. Drug- and alcohol-dependent persons should not lose their civil rights because they are undergoing treatment. The policy of giving preference to voluntary care whenever practicable and of avoiding the imposition of criminal penalties on sick, dependent persons should also be emphasized in legislation. Throughout this book we have stressed the long-standing preference in previous WHO legislative studies, and confirmed by the current survey, for *voluntary* treatment.

In terms of legislative strategy and philosophy, the 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987) suggested that legislation should ensure equitable non-discriminatory access to treatment services located close to the patient's own community. It is also urged that the patient should be allowed legal counsel in any court proceedings. This will be especially important, of course, in cases involving serious criminal charges and where the possibility exists for treatment as a diversion from the criminal justice system.

14.2.3 *Protection of hospital patients' rights*

A wide net should be cast when analysing patients' rights legislation, beginning with specific provisions and moving to the general. It is not our intention to comprehensively cover the field of patients' rights protection. Reference should be made to codes of civil and criminal law and procedure for provisions in each jurisdiction that may apply in practice and may not expressly mention drug or alcohol dependence.

We have reviewed here the legislation summarized in Annex 2, or otherwise included in our legislative survey. Based on this approach, our survey revealed statutory protection of patients' rights in the following categories of civil and criminal legislation:

- laws on psychiatric care and safeguarding of rights;
- mental health legislation specifically mentioning drug or alcohol dependence;
- special civil commitment legislation on drug dependence;
- special civil commitment legislation on alcohol dependence;
- combined drug and alcohol approaches;
- special patients' rights ordinances on the rights and obligations of patients in public hospitals, with special reference to drug-dependent persons;
- special charters setting out the rights of patients and users of health services;
- special legislation on the appointment of an ombudsman or patient advocate, specifically mentioning drug or alcohol dependence;
- legislation on health rights commissions;
- national or subnational 'bill of rights' legislation solely on human rights.
- hospital reform laws;
- social services legislation, specifically mentioning drug and alcohol dependence;
- special legislation for youth or children, specifically mentioning drug or alcohol dependence;
- anti-discrimination legislation for disabled persons, specifically mentioning drug or alcohol dependence;
  legislation banning discrimination against drug- and alcohol-dependent persons, after treatment, in employment;
- criminal justice (penal) legislation, specifically mentioning drug or alcohol dependence.

14.2.4 *Confidentiality of patient records*

There are serious conflicts of public policy concerning the confidentiality of patient records in a treatment programme that is part of an overall national campaign to control drugs and alcohol. Treatment personnel will wish to protect confidentiality to the same extent as in any other clinical stetting, yet information, including information on individuals on court-ordered commitments, is needed by the courts and by control boards

As already pointed out, legislation in many countries requires periodic progress reports to be sent to the courts and control bodies on patients diverted to treatment from the criminal justice system. In some countries, in addition, voluntary treatment is allowed only on first admission, subsequent treatment being authorized only by compulsory commitment on court order. In such circumstances, both the public and the treatment centres are allowed access to the person's previous treatment record, often kept in a national register, in order to determine his or her eligibility for different types of treatment.

The same type of access to the previous treatment record is also necessary in the application of the various diversion procedures for the treatment of offenders outside the criminal justice system. The court-appointed clinical examiners, usually at a treatment centre to which the offender has been sent for evaluation, will need to assess the likelihood that treatment will have some degree of success in order to justify a recommendation that the offender be sent for treatment rather than remain within the criminal process. Both law-enforcement agencies and treatment centres will be reluctant to recommend such diversion if there is evidence that the person has repeatedly failed before, has not complied with the treatment conditions and/or has committed other crimes while in community treatment. If this information is to be verified, strict traditions of clinical confidentiality obviously cannot be preserved.

Except for these practical limitations, however, confidentiality should be maintained. Other persons, including prospective employers, should not be given information about treatment unless the patient consents to its release. This is often in the patient's best interest, since it indicates that he or she has been successfully rehabilitated and has gained new occupational skills.

The patient records of treatment centres may also be used for research and epidemiological purposes by personnel authorized by the designated agency. The names of persons under going treatment may have to be reported and included in national registries of drug- and alcohol-dependent persons, but access to such registries should be strictly controlled under the legislation establishing them. In Hungary it is reported (K. Szomor, personal communication, 1999) that legislation has been enacted providing protection of patient health information, including: *(a)* Law XLVII of 1999 on the handling and protection of personal data in the health care (restrictions on

review of registers and medical data); and *(b)* Law XX of 1996 on the identification methods and codes entering into effect instead of the personal identity numbers. In the United States, Federal regulations promulgated by the Federal Department of Health and Human Services, 42 Code of Federal Regulations Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), provide confidentiality protection for drug- and alcohol-dependent persons.

14.2.5 *Hospital reform*

An example of the protection of patients' rights in national legislation promulgating hospital reforms can be found in France. Law No. 91-748 of 31 July 1991 on hospital reform amends the French Public Health Code, and includes new provisions on the tasks and obligations of health establishments. Health establishments in the public sector may manage facilities for drug-dependent persons, financed from the State budget, under the conditions established by Law No. 70-1320 of 31 December 1970, as amended, relating to the health measures for the control of drug dependence and the suppression of traffic in, and illicit use of, poisons. Under Law No. 91-748, of 31 July 1991, a patient has the right: to a free choice of practitioner and health facility; to information in his or her medical file whether held by a health facility or a practitioner; to confidentiality of medical information; to health establishments that have adequate resources to provide services; and to health establishments that evaluate their activities.

14.2.6 *Protection of patients' rights in subnational legislation*

An example of modern subnational legislation on patients' rights is Decree No. 175/1989 of 18 July 1989 of the Basque Autonomous Community of Spain. The Decree approved the Charter of Rights and Obligations of Patients and Users of the Basque Health Service, in accordance with the provisions of Section 10 of the General Law on Health applicable to patients and users of the Basque Health Services, or services operating under agreement with the Basque Health Services. The Decree establishes the following categories of rights and obligations of patients: general rights; specific rights of the child as patient and user of the Basque Health Services; specific rights of women as patients and users of the Basque Health Service; and obligations of patients.

In Switzerland (Zurich), the Patients' Rights Ordinance of 28 August 1991 establishes the rights and obligations of patients in public hospitals subsidized by the State. The Ordinance lays down the basic principles of rights and obligations in the following areas: treatment; admission; visits; discharge; obligation; instruction and research; inspection; persons in custody; case history for each patient; right of inspection; communication of information to third parties; incompetent patients; after-care; consent; patients incapable of exercising judgement; extension of operations; instructions issued by the patient; patient capable of exercising judgement but

otherwise incompetent; refusal by physicians to carry out interventions; autopsy; transplantation; and consultation of the autopsy report. The Ordinance lays down special provisions concerning mental patients and drug-dependent patients, as follows:

> *Legal protection.* The chief physician shall be responsible for ensuring that patients are only admitted to hospital or detained therein in accordance with the appropriate legal provisions.
>
> *Restrictions.* The patient shall be allowed freedom to the extent that it is beneficial to him and compatible with his own safety and that of the public. Physical constraints shall only be used in an emergency, such measures being recorded in writing. Verbal and written exchanges between the patient and his family or third parties may be subjected to supervision or restrictions imposed by the medical staff, provided that the purpose of such measures is to protect the patient or any other persons.
>
> *Employment.* The patient shall be employed to the extent possible and in an appropriate manner. Compensation may be paid for the work carried out. Compensation does not, however, constitute a right.
>
> *Excursions, holidays, and outside work.* The physician may grant a patient permission to make an excursion, take a holiday, or accept work outside the hospital, provided that the patient's condition so permits. In the case of involuntary commitment, the agreement of the authorities responsible for commitment shall be required if a patient wishes to make an excursion or enter into employment outside the hospital.
>
> *Care in the family environment, and in night and day centres.* Patients who are no longer required to remain in hospital but who still need constant supervision shall, in accordance with the physician's decision, be transferred to a family care environment, or accommodated in a suitable institution. In the case of involuntary commitment, the authorities who committed the patient to hospital shall be responsible.
>
> *Transfer of long-stay patients.* The chief physician shall be authorized to transfer long-stay patients to other appropriate hospitals.

In Italy, the therapeutic and social rehabilitation programme must ensure full respect for the dignity of the person, taking into account all work and study requirements, as well as the family and social living conditions of the patient. Respect for dignity also reflects the principles contained in the Universal Declaration of Human Rights (United Nations, 1948).

14.2.7 *Ombudsman or patient representatives*

The 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987) reviewed the use of specially appointed patient representatives or advocates as one means of providing advice and assistance on legal rights and the treatment of drug and alcohol dependence. It was noted in the guidelines that several countries have provided this kind of service for mental patients; and that such patient representatives are also used in a number of countries in general hospitals, where they help patients to cope with stress, deal with complaints, and seek to improve communication among patients, their families, treatment personnel, the hospital authorities, and the courts. Moreover, it is suggested that patient representatives can also assist in the more formal matters of rights of appeal against compulsory hospitalization or treatment in a closed institution and in relation to alleged violations of patients' rights in treatment as a consequence of improper restraint or other procedures, as well as violations of confidentiality or privacy.

In Finland, the Law on the status and rights of patients, dated 17 August 1992, applies to all patients in health and medical care, and contains provisions specifically on patients' complaints and on a patient ombudsman. Under the complaints provisions, a patient who is dissatisfied with the health care or medical care that he has received, or with any treatment connected with it, has the right to submit a complaint to the person responsible for health and medical care in the unit in question. A decision must be made on the complaint within a reasonable time after its submission. The submission of such a complaint does not restrict the patient's right to lodge a complaint with the authorities in charge of health and medical care concerning the care he has received, or any treatment connected therewith. If, when the complaint is dealt with, it becomes obvious that the care or treatment received is likely to result in liability for patient injury under the Patient Injury Law (No. 585) of 25 July 1986, liability for compensation for damages under the Compensation for Damages Law (No. 412) of 31 May 1974, legal action, the revocation or restriction of the right to perform professional activities, disciplinary proceedings in accordance with the legislation on the practice of professional activities with regard to health or medical care, or disciplinary proceedings in accordance with some other law, the patient must be advised as to how legal proceedings in respect of the matter can be initiated within the competent authority or body. The patient ombudsman must be appointed for health care and medical care units, and the same patient ombudsman may be appointed in two or more such units. The patient ombudsman must: (*a*) advise patients on issues concerning the application of the Law on the status and rights of patients; (*b*) assist patients in the matters referred to in the complaints section; inform patients of their rights; and (c) in general act to ensure that patients' rights are promoted and respected. Without patient consent, information contained in patient records must be kept confidential.

We realize, of course, that not all countries will have the resources to provide services of this type. They do, however, provide an alternative approach to patient protection and satisfaction worthy of consideration. Patient representatives may be attached directly to treatment centres as paid staff or volunteers from the community. They may he attached to a national drug- or alcohol-control coordinating review body; they are then independent of the administration of the treatment centres, which is an advantage when investigating patient complaints or advising on court appeals.

In Spain (Basque Autonomous Community), Decree 175/189, among its provisions, restructures the Patient and User Care Services of the Basque Health Service. These are administrative units responsible for providing care to the users of the public health services, ensuring that their rights and obligations (as specified in the Decree) are observed, and providing them with guidance. The duties of the Patient and User Care Services, as prescribed in the Decree, are as follows:

- to receive information, and to provide guidance to patients and members of their families when they have recourse to, or enter, the health centres of the Basque Health Service;
- to safeguard access to the rights of patients and users, as laid down in the General Law on Health and in this Decree;
- to consider, handle, and take action on all complaints, claims, and suggestions submitted by the users;
- to submit to the competent supervisory body resolutions concerning the complaints or claims presented, or concerning any protective action carried out on their own initiative, in accordance with the relevant regulations in force;
- to ensure observance of the obligations and rules laid down by the directorate of the centre with respect to patients or members of their families;
- to carry out enquiries among users, and to communicate the results to the directorate of the centre; and
- to carry out any other duties intended to improve the hospital stays of patients and users, whether these are assigned by the directorate of the centre or the Area Directorate.

14.2.8 *Non-discrimination*

In Sweden, there is an ombudsman system (Sweden, 1998c) designed as a guarantee against oppressive measures and "misgovernment" in the public administration, and in the judiciary. The Parliamentary Ombudsman's jurisdiction covers inspections of county administrative boards and courts. The Children's Ombudsman's duty is to safeguard the rights and interests of children as provided in the United Nations Convention on the Rights of the Child.

Legislation identified in the current survey on diversion to treatment in the criminal justice system includes statutory provisions in two countries (Bolivia, Venezuela) prohibiting both government and private organizations from discriminating in employment.

In Bolivia, legislation prohibits public or private enterprises from discriminating in the provision of employment to rehabilitated and socially readjusted persons. In Venezuela, the Organic Law Governing Narcotic and Psychotropic Substances of 17 March 1984 provides that the State and private enterprises may not reject rehabilitated and socially resettled individuals when they apply for work, provided that they meet the requirements set by the employer in his offer. Such provisions prohibiting discrimination in employment are consistent with the Declaration on Non-discrimination in the Field of Health (1989/11), adopted by the United Nations Commission on Human Rights (United Nations, 1989). This Declaration reaffirms the importance of the principle of non-discrimination in access to health care, recalls that all human rights must apply to all patients without exception, and that non-discrimination in the field of health should apply to all people and in all circumstances.

14.2.9 *Appropriate treatment*

In Spain (Catalonia), Law No. 20 of 25 July 1985 on prevention and care in regard to potentially dependence-producing substances establishes the right of every drug-dependent person to receive appropriate health and social treatment. In addition, the social environment of the person concerned must be taken into account in the determination of the treatment that he is to undergo, the health and social resources involved in drug dependence must be coordinated, and the necessary centres and facilities must be established. Under Section 10, drug-dependent persons may undergo detoxification treatment as an inpatient or as an outpatient in a specialized hospital or in a specified general hospital. Section 23 provides that the Public Administration is to provide aid to associations of former alcoholics.

14.2.10 *Health commissions*

The principal objectives of other legislation include the oversight, review and improvement of health services by establishing accessible, and independent facilities. Thus the Health Rights Commission Act 1991 of Australia (Queensland) is designed to preserve and promote health rights; to receive and resolve health service complaints; to enable users and providers to contribute to the review and improvement of health services; to provide education and advice in relation to health rights and responsibilities and the resolution of complaints about health services, whether or not made under the Act; and to assist users and providers to resolve health service complaints. The Act also provides for the establishment of a Code of Health Rights and Responsibilities, for the appointment of a Health Rights Commission, a Health Rights Commissioner, and a Health Rights Advisory Council. The Act sets out seven principles which are to be followed by the Commissioner in determining the content of the Code of Human Rights and Responsibilities, as follows:

1. An individual should be entitled to participate effectively in decisions about the individual's health.
2. An individual should be entitled to take an active role in the individual's health care.
3. An individual should be entitled to be provided with health services in a considerate way that takes into account the individual's background, needs and wishes.
4. The individual who provides a health service or provides care for another individual receiving the health service should be given consideration and recognition for the contribution the individual makes to health care.
5. The confidentiality of information about an individual's health should be preserved.
6. An individual should be entitled to reasonable access to records concerning the individual's health.
7. An individual should be entitled to reasonable access to procedures for the redress of grievances with respect to the provision of health services.

14.3 Protection of drug- and alcohol-dependence as a disability

In Bolivia, Regulations on the Prevention of Disability and the Rehabilitation of the Disabled, dated 15 March 1982, define the term "disability" as any limitation on the ability of an individual to carry out any activity necessary for his development as a consequence of a physical, psychological, or social defect. Under these Regulations, persons suffering from social disability include alcoholics and drug-dependent persons. The Ministry of Social Welfare and Public Health is required to: (1) act as a technical advisory body on the prevention of disability and the rehabilitation of the disabled at

the request of the public and private sectors; (2) promote the dissemination of preventive and rehabilitative measures with regard to disability; (3) incorporate in its programme scientific and technical advances in the field of rehabilitation; (4) promote the establishment of institutions for the rehabilitation of the disabled; and (5) promote the manufacture of equipment, instruments, apparatus, prostheses, and orthopaedic devices which it considers necessary for the comprehensive rehabilitation of the disabled. Under Section 37, emergency medical institutions that provide care for alcoholics must refer them to specialized institutions for appropriate rehabilitation.

In the United States of America, the Americans with Disabilities Act, 42 United States Code Section 12101, dated 26 July 1990, protects alcohol-dependent or drug-dependent persons with a history of alcohol or drug problems from a variety of proscribed discriminatory practices. The term "disability", as defined in the Act, means, with respect to an individual: (*a*) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (*b*) a record of such an impairment; or (*c*) being regarded as having such an impairment. However, Section 104 of the Act provides that the term "qualified individual with a disability" does not include any employee or applicant who is currently *engaging* in the illegal use of drugs'. Moreover, Section 511 provides that the term "disability" does not include psychoactive-substance-abuse disorders *resulting* from *current* illegal use of drugs.

14.4 Individual responsibilities

As stated in the 1987 Guidelines (curran, Arif & Jayasuriya, 1987) those persons undergoing treatment of any type may be required, as a condition of continuing to receive such treatment, to comply with the prescribed treatment schedules, including rehabilitation and vocational training, and submit to surveillance measures, such as urine analysis and other means of detecting drugs or alcohol in the body.

14.4.1 *Individual responsibilities in treatment-based drug court programmes*

Treatment-based drug courts set out specific criteria to which defendants must conform their conduct as part of carefully structured treatment programmes. Judges establish their guidelines which establishes what constitutes successful and unsuccessful participation while in treatment (Weitzman, J.J., undated).

For example, in the United States of America (Florida), legislation (Florida Statutes §948-08(2), 1993) provides that "any person who is charged with any nonviolent felony of the third degree is eligible for release to the pretrial intervention programme ....". Several components of this programme place the responsibility for treatment success - and potential release from trial - on the drug dependent defendant, as follows: the defendant must waive the "speedy trial" (due process protection under

U.S. law) provisions and enter the treatment programme; the victim, state attorney, and judge of initial appearance must consent to the admission to the programme; criminal proceedings resume against the defendant whenever the state attorney or programme administrator determines that the defendant is not fulfilling the programme obligations (Drug Court Clearing House & Reference Collection, 1998).

Moreover, also in the United States of America, under provisions of the Model Criminal Justice Treatment Act, a treatment programme may immediately discharge an individual who fails to comply with programme rules and treatment expectations or who refuses to "constructively engage in the treatment process" (U.S. Model Criminal Justice Treatment Act, 1993).

14.4.2 *User responsibility*

The doctrine of user responsibility or user accountability is found in many legislative provisions in the current survey. The concept is that the use of illicit drugs, or the abuse of alcohol, makes the user personally and individually responsible and accountable for such use, and therefore subject to the imposition of sanctions by the State. For example, in Venezuela, under the provisions of the Organic Law Governing Narcotic and Psychotropic Substances of 17 March 1984, previously mentioned, the father and mother will be deprived of their parental rights whenever:

- they may compromise the health, safety or morality of their children through habitual consumption of the substances referred to in this Law;
- they use them for any of the offences envisaged under this Law;
- the extent of the offensive behaviour envisaged under this Law transcends the home or influences the development of the children; or
- they consent to their children consuming any of the substances referred to in this Law, unless they can demonstrate the opposite.

14.4.3 *Security measures in treatment centres*

Reasonable security measures are necessary in treatment centres, including surveillance to prevent receipt of contraband drugs and alcohol, and weapons.

For example, in Sweden, Law No. 12 of 10 January 1985 on the control of intoxicants in hospitals applies to hospital units specializing in the care of persons abusing dependence-producing substances. Section 2 prohibits persons admitted for care from possessing alcoholic beverages or other intoxicants. The possession of hypodermic syringes and needles that can be used for the abuse of narcotics is also prohibited.

14.4.4 *General patient requirements*

The obligations of users of general health services are established by laws together with implementing regulations or decrees. In Spain (Basque Autonomous Community), the Charter of the Rights and Obligations of Patients and Users of the Basque Health Service, previously mentioned, requires patients, users, and members of their families, when using the health services of the Basque Health Services, to comply with the following obligations:

- cooperate in complying with the standards and instructions drawn up in the health institutions;
- treat with all due respect the staff of the health institutions, other patients, and persons accompanying them;
- look after installations, and collaborate in maintaining health institutions in habitable condition;
- sign a voluntary discharge document in cases of non-acceptance of the methods of treatment;
- inform those responsible for health institutions of any irregularities observed in the operation of the centres;
- carry the personal health card whenever required to do so by the health services; and
- use the emergency services for the purposes for which they are intended, by having recourse, preferably, to units providing ordinary services.

In San Marino, Law No. 43 promulgating the Charter of Patients' Rights and Duties, provides that, in addition to the rights enumerated, each citizen has the following duties: (1) to keep himself informed, thereby facilitating the rational management of his pathological state; (2) to respect the needs and work of other persons; (3) to cooperate with medical staff in the performance and improvement of activities; (4) to adopt a comprehensive approach to problems, without restricting his view to his own disease; and (5) to contribute actively, through community life and participation in local bodies, to the planning, choices, and management of health facilities.

In Bahrain, the working policy of the State of Bahrain Ministry of Health Psychiatric Hospital for the drug and alcohol unit provides that inpatients undergoing treatment are expected to comply with all the terms of the treatment contract (see box).

Ministry of Health Psychiatric Hospital Treatment Contract

Dear friend,

In order to help you overcome your present problems and make your stay with us as comfortable as possible, you are requested to follow these rules and regulations:

1. The staff acknowledge that addiction is a very traumatic experience and that your dependence on drug or alcohol is affecting all other aspects of your life. We expect you, therefore, to put aside all other considerations and dedicate all of your personal efforts towards overcoming your dependence on drugs/alcohol.
2. We are here to help you. We expect that your relationship with members of the team should be based on mutual trust. You will be given all possible privacy and we would like to assure you that all precautions are taken to ensure confidentiality with regard to your drug/alcohol and personal problems.
3. We expect you to accept responsibility for your behaviour and to acknowledge and respect the rights of others. Any violation of patients' or staff rights will be taken seriously and dealt with appropriately.
4. You are expected to participate actively in group meetings and discussions. These will focus upon the personal experiences of group members with regard to their drug/alcohol problems. Any specific medical problems will be dealt with outside the group.
5. You are not allowed to bring or use drugs in the unit without a prescription from the unit doctor.
6. You are not allowed to leave the ward. Only first-degree relatives will be allowed to visit during visiting hours. No more than two visitors are allowed at a time.
7. You are expected to use your own clothes and provide your own toiletry.
8. It is our policy to search all personal property on admission and at any other times during your stay.
9. You are expected to remain in the recreation area when the ward is being cleaned, and adhere to meal and medication times.
10. You are expected to actively participate in all unit activities.
11. Please do not smoke in bed as it is dangerous.
12. You are not permitted to keep any sharp instruments. Hospital property must not be abused or taken away.

Those who violate unit policy or continue to use drugs/alcohol will be discharged immediately.

Patient's name:	.....	Doctor's name:	.....
Signature:	.....	Signature:	.....
Date:	.....	Date:	.....

15. AIDS legislation: bridge to treatment

15.1 General

Key country informants were asked whether policies, laws and regulations contained separate provisions on the treatment and rehabilitation of special populations. We asked specifically about legislation relating to treatment and rehabilitation for HIV infection and AIDS. There is a large and growing literature on the analysis of policy and laws concerning HIV infection and AIDS. However, this Chapter is concerned solely with the relatively narrow part of HIV and AIDS legislation that serves as a bridge to drug or alcohol treatment and rehabilitation. Some legislation is directed at addressing risks of infection associated with used syringes and needles, such as the provisions of Letter DGS-DIV-SIDA No. 95-1320 of 15 October 1995 on the prevention of AIDS in intravenous drug users and the recovery of used syringes.

A related discussion of government policy objectives can be found in Chapter 7. National and subnational drug- and AIDS-control strategies increasingly include policies addressing HIV-infected persons and drug-users; however, legislation has been slow, generally, to provide the legislative mechanisms needed to implement policy.

Table 16 shows the areas covered by HIV and AIDS legislation as a bridge to drug or alcohol treatment and rehabilitation.

Table 16 HIV and AIDS legislation as a bridge to drug or alcohol treatment and rehabilitation

Area covered	Countries
Providing for methadone maintenance; treatment Heroin trials leading to abstinence	Austria, Italy, Spain (Federal, Andalusia), Sweden, United States of America (Federal) Switzerland (Federal)
With treatment required or offered, permitting lawful needle exchange by injecting drug users	Australia (New South Wales), New Zealand, United Kingdom, United States of America (Connecticut, Hawaii).

15.2 Methadone maintenance or substitution treatment

In response to the AIDS pandemic, some governments have adopted strategies aimed at increasing the use of orally administered methadone by injecting drug users at risk for HIV infection through needle sharing. In some jurisdictions, methadone is intended for maintenance, while in others it is part of a treatment programme.

Some examples of legislation implementing this strategy can be found in the following countries and jurisdictions in the WHO European Region: Austria, Italy, Spain (Federal, Andalusia), Sweden. The United States of America (Federal) has recently enacted administrative provisions in this area.

In Austria, in the light of the increasing risk of HIV infection among injecting drug users, the Advisory Board on Alcohol and Drug Abuse recommended in January 1987 that a pharmacological substitute treatment should be introduced (I. Erlacher, personal communication, 1994). As a result, the Minister of Health issued a Federal Chancellery Regulation (62.61.51/14-VI/14/87 of 25 September 1987) of the Federal Chancellery on oral substitution therapy for intravenous drug users, in conformity with the provisions of Section 5 of the Narcotics Law. Under the Decree, injecting drug users receiving substitute treatment must be above the age of 18, they must prove that they have previously several times undergone treatment aimed at making them drug-free without success and/or are infected with HIV, whether or not they have manifest clinical symptoms. The Austrian Government not only subsidizes treatment facilities for drug-dependent persons but also provides funding for the psychosocial counselling or psychotherapy of patients undergoing substitute treatment. Although methadone treatment is now available, the number of injecting drug users seeking treatment increased in 1988 as compared to previous years. HIV-positive drug-dependents are admitted to treatment centres in the same way as other drug-dependents. In France, an internal circular of the Ministry of Health of 7 June 1993 extends experimental programmes involving methadone in order to reduce the risks and promote the adoption by drug-dependents of prevention programmes. The aim of the substitution programmes is also to ensure better social integration, and moderation or even cessation in the long term of drug taking. The circular also provides for the setting up of help centres for drug-dependent persons.

In Greece, the introduction of the use of opiate substitutes for maintenance treatment under Article 12 of Law 216/93 was primarily due to concerns regarding the spread of HIV infection and AIDS among injecting drug users and from them to the general population. HIV/AIDS prevention, treatment and rehabilitation policies are implemented by the Ministry of Health in collaboration with the relevant medical institutions. Decree No. 162/1990 of Spain (Andalusia), dated 29 May 1990, regulates the treatment with opiates of opiate-dependent persons. This Decree includes provisions for establishing a commission for the accreditation, evaluation, and control of centres or services, and for admission for treatment.

In Norway, it is reported (Norway, 1996) the government adopted an approach of methadone treatment for heroin addicts, following a pilot methadone project involving 50-60 drug users, in Oslo. In Sweden, Regulations No. 16 of 15 June 1990 of the National Board of Health and Welfare on methadone maintenance treatment and the prescribing of opiates on the grounds of the indication of drug dependence, repeal Regulations No. 4 of 1988 and provide for the establishment of a national programme intended to deal with up to 450 drug-dependent injecting drug users by providing them with maintenance treatment and detoxification using methadone.

Some jurisdictions have revised administrative rules in order to provide greater flexibility and wider availability of methadone services. For example, in the United States of America, the Federal Food and Drug Administration (FDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have revised the conditions for the use of methadone in the maintenance of narcotic addicts. The final rule (methadone in maintenance treatment of narcotic addicts; joint revision of conditions for use; interim maintenance treatment; human immunodeficiency virus disease counselling) permits, contingent on FDA and State approval, public and non-profit-making private narcotic treatment programmes to provide interim maintenance treatment to patients awaiting placement in comprehensive maintenance treatment, and requires all narcotic-treatment programmes to provide counselling on preventing exposure to, and the transmission of, HIV.

15.3 Heroin prescription trial

In at least one jurisdiction heroin is being prescribed on an experimental trial basis. In Switzerland, the Ordinance of 21 October 1992 on the evaluation of projects aimed at preventing drug dependence and improving the living conditions of drug-dependent persons, permits the Confederation to conduct up to five trials for the prescribing of heroin, limited to 50 drug-dependent persons per trial. The legislative purpose of the trials is to determine the effectiveness of such treatment as a stage towards abstinence.

Pursuant to the Amendment of 21 February 1996, the Ordinance on the evaluation of projects aimed at preventing drug dependence and improving the living conditions of drug-dependent persons, provides, in part, as follows: "

> that drug-dependent persons who have participated in trials until their completion, may, if this is medically indicated, continue to receive intravenously administered heroin, morphine and methadone with a medical prescription; and that the provisions of the Ordinance that relate to projects and trials, shall by analogy, be applicable to prescription. Moreover, the Federal Office for Public Health must ensure that long-term scientific studies are carried out on drug-dependent persons for whom intravenously administered heroin, morphine or methadone

continues to be prescribed in accordance with this Ordinance, and that the provisions concerning evaluation shall, by analogy, be applicable to long term studies and other clinical studies."

15.4 Needle and syringe exchange

Needle and syringe exchange is controversial in many countries. While many governments support needle-exchange programmes, many do not, concerned that the exchange of needles and syringes encourages drug dependence. This book is concerned with treatment and rehabilitation for drug and alcohol dependence. In those jurisdictions where sterile needle and syringe exchange is lawful, needle-exchange programmes should also be a bridge to treatment by including effective and funded treatment components. Thus, the WHO Global Programme on AIDS[1] has concluded (World Health Organization, 1995b) that, in conjunction with providing information, education, prevention, and counselling and drug treatment, sterile needle and syringe exchange should be explored in the context of reducing harm from drug use.

It is reported (D. McDonald, personal communication, 1994) that in Australia, although drug-control policies and AIDS policies have evolved 'more or less in parallel', some difficulty has been encountered in aligning them, but that in recent years policies and legislation have become better targeted to needs. It is reported further that most states in Australia have enacted legislation to increase the availability of clean injecting equipment, methadone programmes have been expanded and HIV-infected drug-dependent persons are generally considered to have easier access to them than in the past, and that prison drug-treatment programmes, including methadone programmes, have expanded in some states. Preventing use and harm is among the eight priority areas identified for future action under the National Drug Strategic Framework 1998-1999 to 2002-2003 federal strategy, to reduce harm caused by drugs in Australian communities (Australia, 1998). State and Territory police and public health services are seeking intersectoral collaboration to respond to harmful drug use. For example, police services have developed guidelines intended to facilitate the operation of needle exchange programmes (Australia, 1998).

Preparing legislation on needle supply is complex, primarily because drug-control laws in various jurisdictions require the prosecution of persons who possess or use drugs, or possess needles. However, legislators have generally approached the preparation of legislation on needle-supply programmes by: (1) amending criminal laws (e.g. on drug paraphernalia) to exempt or exclude from proscription the activities of both the supplier and user; and (2) affirmatively setting out the positive requirements

[1] Predecessor of the Joint-United Nations Programme on HIV/AIDS (UNAIDS), supported by six United Nations organizations: United Nations Children's Fund (UNICEF), Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Educational, Scientific and Cultural Organization (UNESCO), WHO and the World Bank.

of programme (e.g. demonstration needle exchange in a prescribed geographical area), including time limitations and evaluation.

In countries with federal or equivalent systems (e.g. Australia, Switzerland, United States of America), legislation on needle distribution and exchange has been enacted at the subnational level (e.g. state, canton) consistent with federal drug-control laws and other laws on communicable diseases, professional practices, and the criminal law. Administrative procedures can take the form of regulations, directives, or circulars which authorize certain actions, approve or license personnel or otherwise facilitate the conduct of needle-supply programmes.

In Switzerland, the Federal Law on Narcotics, dated 30 October 1951, as amended, permits discretion not to prosecute when treatment will be provided and rehabilitation is to be expected. For those who accept medical care, the Law provides for diversion from prosecution for the use or possession of unlawful drugs. Interpreting this provision as encouraging treatment, health officials try to make contact with drug-abusers. In some jurisdictions, the cantonal authorities forego law-enforcement action consistent with this interpretation (Porter & Gostin, 1991). The Swiss Federal Office of Public Health has urged that the health and living conditions of drug-dependent persons should be improved. Support has been provided to programmes for the distribution and exchange of sterile needles and syringes to injecting drug-users, to places where users can inject (e.g. in Zurich, Basel, Berne and Geneva), and to the provision of emergency assistance to injecting drug users. According to the federal public health authorities (Switzerland, 1994), the distribution of syringes, e.g. in Zurich, continues but contacts for social and medical aid have been restricted. In France, a series of provisions, (Decree No. 95-255 of 7 March 1995 amending Decree No. 72-200 of 13 March 1972; Order of 7 March 1995) facilitate the dispensing of sterile needles and syringes both by pharmacies and outside the pharmacy dispensing network.

In the United States of America, at the federal level under the provisions of Public Law 105-78, federal funds to support needle exchange programmes were conditional and determined by the Secretary of the Department of Health and Human Services (DHHS) that such programmes reduce HIV transmission and do not encourage the use of illegal drugs. On 20 April 1998, the DHHS Secretary announced that a review of research findings indicated that needle exchange programmes do not encourage the use of illegal drugs and made a determination to this effect. The administration's view is that local communities should make their own decisions, and provide funds, if they choose needle exchange programme.

In the United States jurisdictions in several states (e.g. Connecticut, Hawaii) have adopted legislation on establishing, operating, and evaluating needle-supply programmes, including a requirement for treatment. In Hawaii, Act 280 relating to a pilot programme to reduce the transmission of infectious and communicable diseases, dated 25 June 1990, authorized a two-year pilot programme on needle and syringe exchange to combat the spread of HIV and other communicable diseases. This was the

first state-endorsed, statewide syringe-exchange programme in the United States. The Hawaii, legislature stated its findings in the Act, including the finding that a well-designed sterile needle and syringe exchange programme has been proven effective in preventing the transmission of HIV. Data from studies in other states of the United States and other countries demonstrate that needle-exchange programmes apparently do not increase drug use and do not attract new users, but result in a significant increase in requests for drug treatment, and an increase in requests for HIV testing and counselling. They also constitute an effective method of reaching hard-core and normally inaccessible users. The Hawaii Act requires the Director of Health of Hawaii to establish an exchange programme in accordance with the following conditions: the programme must be designed to prevent the transmission of HIV and hepatitis B virus (HBV); and it must be operated under maximum security for the sites and equipment; it must be a one-for-one exchange; and it must screen participants to preclude non-injecting drug-users from participating in the programme. The Act also provides (in Section 2) that, as a condition of the continued operation of the pilot programme, the Hawaii Department of Health must provide drug-abuse treatment, counselling, and educational services to all participants. If a participant requests treatment, a treatment slot must be made available to that participant. The programme must include, but not be limited to, the education of the drug-user as to the dangers of contracting HIV infection through needle-sharing practices, the offer of counselling to assist addicts in rehabilitating and productively reintegrating into the community, and the provision of treatment to overcome the dependence on drugs. In addition, the programme must undertake research on behavioural changes and enrolment in treatment. The programme has been particularly successful in connection with drug-treatment referrals (Hawaii, 1990).

In the United States of America (Connecticut), the Connecticut General Assembly has enacted legislation authorizing the establishment of a demonstration needle-exchange programme in the city of New Haven. It was reported (New Haven, 1990) that New Haven had the highest incidence of HIV infection among intravenous (IV) drug users in the state (72% of reported AIDS cases were associated with IV drug users). The legislation (Act Concerning a Demonstration Needle and Syringe Exchange Programme, Public Act No. 94-16 of 28 April 1994) amended state needle-prescription and drug-paraphernalia laws, which prohibited the sale or possession of needles or syringes without medical prescription. The new Act added the demonstration project to a list of exceptions to the prescription requirement in the needle prescription statute (Connecticut General Statutes, Section 21a-65(a)), and exempts needle-exchange programme participants from penalty for the delivery, use or possession of drug paraphernalia to inject controlled substances. As reported (New Haven, 1990), reducing the prevalence of needle sharing among intravenous drug-users (the primary mode of HIV transmission) was the main objective of the project. Another objective was to reduce sexual transmission of HIV by increasing condom use among active intravenous drug-users and their sex partners. By decreasing the risk of infection to women via sexual or needle transmission, the needle-exchange programme was also designed also to help to curb perinatal transmission. Secondary objectives

were to motivate and actively assist injecting drug users to enter treatment for drug dependence, and to reduce the risk of exposure of the general community by to contaminated needles by minimizing the number of needles and syringes discarded in public places. During the first year of operation, the New Haven Health Department sought to maximize the number of IV drug users participating in the needle-exchange programme; maximize the percentage of needles and syringes issued by the programme that are returned to it; minimize the number of active IV drug users who drop out of the programme; and enable those addicts desiring rehabilitation to enter treatment for their drug dependence (New Haven, 1990).

In Zimbabwe, it is recognized (A. Chidarikire, personal communication, 1994) that injecting drug users with HIV infection or AIDS pose a health problem due to the risk of infection through the sharing of syringes and needles. Abuse of drugs or alcohol is reported (P.S. Madzonga, personal communication, 1994) to be generally associated with careless sex, thereby increasing the risk of contracting AIDS, and the use of injectables exposes drug abusers to AIDS. It is also reported (A. Chidarikire, personal communication, 1994) that the Public Health Act is in process of being amended to include provisions for the prevention, control and treatment of HIV infection and AIDS. The current policy of the Ministry of Health and Child Welfare is to promote the use of disposable syringes and needles in preference to those that can be resterilized.

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