8. Programme implementation and evaluation

8.1 National advisory and coordinating bodies

Our survey revealed a continuing trend towards the establishment of national advisory and coordinating bodies on drug and alcohol dependence to provide guidance to governments at the national and subnational level. These bodies frequently take the form of drug or alcohol commissions, narcotic boards, or interministerial committees for drug or alcohol programmes. They are of special interest because of the link between policy development, programme planning, and legislative enactments. Some countries, however, have not established coordinating bodies, preferring informal consultation between different ministries. In this connection, it is recommended in the 1987 Comprehensive Multidisciplinary Outline (United Nations, 1988) that national authorities should (in collaboration with nongovernmental agencies) consider establishing a nationwide coordinating body to be responsible for coordinating and guiding the development and maintenance of a comprehensive treatment programme for drug dependence.

The establishment of coordinating bodies has been stimulated by the emergence in recent years of legal requirements for the development of national policy strategies, which call for the coordination of activities. As pointed out in a previous WHO study (Curran, Arif & Jayasuriya, 1987), the most effective coordinating bodies share the following characteristics: (*a*) high-level governmental backing; (*b*) strong political support; (*c*) adequate funding; (*d*) high-level and respected membership; (*e*) public support; and (*f*) prominent public visibility and high priority in all areas of government.

The membership of the coordinating body will usually depend on its mission, and may include the prime minister as chairperson, together with the ministers of justice, agriculture, penal establishments or prisons, public safety, interior, health, social welfare, education, revenue and customs, and transport. Non-ministerial appointees may include representatives of the judiciary, the professions, the clergy, business leaders, and women's groups. For example, in Thailand, the Office of the Narcotics Control Board (ONCB), an agency under the Office of the Prime Minister, acts as a central coordinating body for narcotics prevention and control as well as carrying out the assignments of the Board. This is chaired by the Prime Minister, with the Secretary-General of the Narcotics Control Board as member and secretary. In Egypt, the coordinating body is the National Council to Combat and Treat Addiction and Abuse, headed by the Prime Minister. It includes as its members the Ministers of Justice, Interior, Defence, Health, Social Affairs, Mass Media, High Education, Manpower and Training, Local Government, Education, and Culture, together with the Head of the Higher Council for Youth and Sport, and the Director of the National Centre for Social and Criminal Studies.

A representative of the treatment centres should be a member of the coordinating body, and we also recommend that its title should include a reference to treatment and rehabilitation. In Bahrain, treatment is the main focus because the National Committee of Mental Health, located at the central psychiatric hospital, is the national coordinating body. It is chaired by the Assistant Undersecretary for Hospitals Training. The other ministries involved are Health, Information, Labour and Social Affairs, Education, Interior, Justice, and Islamic Affairs. Bahrain University, the philanthropic societies, the Bahrain Society of Sociologists, and the Bahrain Medical Society are also represented. The power to cooperate with such national coordination bodies should be clearly specified in the drug- and alcohol-treatment legislation; our current survey shows that national coordinating or advisory bodies have been established, by legislation, in each of the six WHO regions.

In the African Region the following countries were reviewed: Algeria, Cape Verde, Ivory Coast, Ghana, Togo, and Zimbabwe. In the Region of the Americas, such bodies have been established in Belize, Canada, Costa Rica, Dominica, Ecuador, Mexico, Saint Lucia, United States of America, and Venezuela. Syrian Arab Republic established a coordinating body in the Eastern Mediterranean Region, and Papua New Guinea set up a body in the Western Pacific Region. In the South-East Asia Region, India established a narcotic drugs and psychotropic substances consultative committee; and as previously noted, in Thailand, the Office of the Narcotics Control Board coordinates drug prevention and control.

These bodies included both commissions for the ongoing control of dependence-producing drugs, or the control of alcoholism, and special commissions on specialized issues (e.g. AIDS) requiring focused and timely actions. Thus commissions with the general objective of drug control have been established (in Algeria, Cape Verde and France), and a commission for the control of alcoholism in Hungary. In Italy, Law No. 135, of 5 June 1990, established a programme of urgent interventions for the prevention and control of AIDS, designed to prevent the spread of HIV infection. It authorized the National Commission for the Control of AIDS to strengthen services for drug-dependent persons through the recruitment of health and technical personnel.

We found several instances of the appointment of advisory councils, e.g. Alcohol Concern and the Standing Council for Drugs Advice in the United Kingdom (J. Waterson, personal communication, 1994).

Inadequate financing is a continuing problem increasingly addressed by high-level bodies coordinating policy. Effectiveness is often limited because of lack of funding and other resources, especially professional personnel and materials (e.g. transport and money). In Egypt, a coordinating body of the National Council to Combat and Treat Addiction and Abuse is in process of development; it will coordinate and finance activities at the local level, based on a fund (established by legislation) for use in both drug control and treatment.

Coordinating and advisory bodies can be effectively used to facilitate communication, advice, and coordination of policies in the drug and alcohol fields.[17] They may adopt policy statements, but if specific tasks are not assigned, little actual progress will be made. There was a clear consensus that such bodies, with their broad representation, can be helpful, but often failed to live up to expectations. For example, when a country establishes a central body which fails to function effectively within a reasonable time, its credibility and influence are severely eroded. It was agreed that members of advisory bodies need careful selection and clear-cut objectives, together with wide participation by nongovernmental organizations and community groups.

The objectives of these bodies vary, but may include regulation of the use and abuse of drugs, development of guidelines for the treatment of alcohol- and drug-dependent persons, and the implementation of international treaties on these subjects by the enactment of national implementing legislation. In Togo, for instance, Order No. 37-MJ-CT1 of 30 September 1985 establishes an interministerial commission responsible for the implementation of the international treaties on narcotics and psychotropic substances. Similarly, in 1995, the Lithuanian Ministry of Health established a Narcotics Commission, responsible for the control of the legal sale of narcotics and psychotropic substances according to the requirements of international agreements (Lithuania, 1999).

The duties of such bodies should be as broad as possible, covering all aspects of supply, distribution, regulation of use, licensing, treatment, rehabilitation and education. Legislation on the treatment of drug- and alcohol-dependent persons should designate a specific authority (e.g. an agency) to conduct, supervise and coordinate comprehensive treatment services for drug and alcohol dependence. The coordinating body can ensure the timely implementation of legislative provisions by marshalling all available resources, public and private, in a variety of settings, and the most modern methods of treatment and rehabilitation. It can clarify the legislative authority given to it to develop, coordinate, supervise, and evaluate clinical services and social services for drug- and alcohol-dependence programmes.

Each country will, of course, establish the most appropriate agency or agencies for this purpose, e.g. the ministry of health or a newly created body, such as a national board for drug and/or alcohol control and treatment. Whatever the agency established, the aim is to centralize the leadership of such programmes and to ensure effective coordination of treatment services. The integration of treatment services for drug and alcohol dependence with community health services may be advisable in many

[17] Participants at the Harvard Advisory Group meeting considered the question of coordinating and advisory bodies and their role in alcohol- and drug-treatment systems in various countries. The main elements of a paper presented at the meeting by Dr Agustin Velez Barajas are stated in this paragraph (A. Velez Barajas, unpublished observations, 1994).

countries. Treatment programmes will often be under the authority of the ministry of health, although they may be coordinated as already suggested, by a national board for drug and/or alcohol control and treatment. This is important when developing community-based services and seeking to associate them with other local primary health services.

In a previous WHO publication (Curran, Arif & Jayasuriya, 1987) guidelines were presented on the legislative designation of a coordination agency for treatment and rehabilitation services. Responsibility for the treatment and rehabilitation programme should be clearly assigned to a particular authority. Although this should be designated in the legislation, it should not operate in isolation and independently of other relevant health services. In fact, the designated agency should, in the legislation itself, be directed to coordinate the comprehensive programme of treatment, rehabilitation, community and patient education, and epidemiological and other scientific research outlined in the preamble of purpose. It should also be required to collect the data needed in order to determine where the available resources can best be utilized. In Hungary, it is reported (K. Szomor, personal communication, 1999) that Decree 187/1998 (XI.13) on implementation (National Statistical Data Collection System) requires data collection for legal production and trade, treatment of drug addicts, mortality, HIV/AIDS and court proceedings. In Mexico, Decree of 16 June 1993 establishes the National Institute for Drug Control as a decentralized technical body under the Attorney General of the Republic of Mexico. One of the Institute's objectives (Section 2) is the "preservation of the health of the inhabitants of Mexico", within the framework of policies prepared by the Attorney General, including a statistical system for drug control to determine trends at both national and international levels.

The agency should, in addition, be directed to cooperate with other public bodies, such as law-enforcement agencies and the national drug and alcohol control board. It is this agency which will be accountable to the legislature for the progress of the programme and for its eventual successes or failures in the treatment of drug- and alcohol-dependent persons. For example, in France, Decree No. 96-350 of 24 April 1996 (on the Inter-Ministerial Committee for the Control of Drugs and Drug Dependence and the Inter-Ministerial Mission for the Control of Drugs and Drug Dependence) sets out that one of the tasks of the Inter-Ministerial Committee is to promote care and social integration of drug-dependent persons.

Interagency advisory committees often lack budgetary support and power. Public recognition, political support, and success are often associated with policy-making agencies charged with coordinating the directives of the country's chief executive officer. Such agencies must be sensitive to the philosophical approaches that form the basis of the policy that is to be implemented in drug and alcohol treatment and rehabilitation.

The primary aim of the drug policy pursued in the Netherlands is to minimize the risks of drug use for the individual drug users, their immediate environment as well as society at large (Netherlands, 1992, 1993, 1999c). It is reported (I.P. Spruit, personal communication, 1994) that, although the attention focused on issues associated with drug-related crimes and drug trafficking sometimes seems to overshadow concern for health problems, the focus on health has always been kept in mind during policy development. The Minister of Health, Welfare and Sports, and the Minister of Justice are both responsible for drugs policy; however, because of the emphasis on health, the Minister for Welfare, Health and Cultural Affairs is responsible for coordinating the Netherlands' Government drug policy (Netherlands, 1999c). There are two aspects to this policy: the enforcement of the Opium Act (1919, amended 1928, 1976) and policy on prevention and treatment. Responsibility for implementing the Opium Act rests with the Minister for Welfare, Health and Cultural Affairs for the licit aspects (i.e. strict supervision of the production and medical use of drugs), and the Minister of Justice for the illicit aspects (i.e. law-enforcement policy). The Interministerial Steering Group on Drug Misuse Policy was set up in 1974 to coordinate the work of several ministries. In 1982 the Group's responsibilities were extended to include policy on alcohol misuse.

In practice, the usefulness of the high-level coordinating body often lies in communication, and in the intersectoral nature of the membership, which facilitates discussion and the transmission of information from all the relevant national agencies. This body can be used, for example, to evaluate current policies and to provide the basis for future actions. It is reported (A. A. Rojo, personal communication, 1994) that prevention and rehabilitation in Bolivia are under the authority of the National Secretariat for Social Protection (together with the subsecretariats for Alternative Development and for Controlled Substances) in order to coordinate both supply- and demand-reduction activities. This integration is considered (A. A. Rojo, personal communication, 1994) particularly useful for obtaining political support from the Government for all programmes aimed at reducing supply and demand, which makes for more effective action.

In Austria, it was reported (I. Erlacher, personal communication, 1994) that criminal activities connected with illicit drug use and trade are given high priority; supervision and control are the main tasks of the law-enforcement agencies. However, drug dependence is considered primarily as a psychosocial problem and an illness. The Narcotic Substances Act of 1 January 1998, continues the policy approach of prior legislation – "therapy instead of punishment" (Austria, 1998). The Federal Ministry of Labour, Health and Social Affairs has primary responsibility for federal drug policy (Austria, 1998). Several coordinating bodies have been established, including: (a) federal drug coordination (three members representing the Federal Ministry of Labour, health and Social Affairs, the Federal Ministry of the Interior, and the Federal Ministry of Justice) established as the control coordinating organization at the national level; and (b) regional addiction or drug advisory boards (provincial group with representatives from institutions, police and other parties) (Austria, 1998).

In Germany, in 1998, the Drug Commissioner stated: "The dependence on addictive substances is a disease that must be taken seriously. Dependent individuals must be given assistance using all medical, therapeutical and social means available. As a consequence, the Federal Government, by a decision taken by the Federal Cabinet on 18th November 1998, transferred the office of Drug Commissioner of the Federal Government from the Ministry of the Interior to the Ministry for Health. This shift documents that in drug policy, emphasis in future will be on health and social aspects. The control of criminal drug traffic continues to be an indispensable task within the remit of the Minister of the Interior." (Germany, 1998).

In some jurisdictions (e.g. India, Zimbabwe), legislation enabling the creation of coordinating bodies give the lead responsibility to welfare or "social defence" ministries (India, 1991). Both drug and alcohol dependence may be covered. In Zimbabwe, it is reported (S.W. Acuda, personal communication, 1994) that the Department of Social Welfare in the Ministry of Labour, Manpower Planning and Social Welfare has been officially designated as the coordinating body. It is responsible for the development and coordination of a national action programme for both alcohol and drug dependence, with special emphasis on the identification, treatment, social rehabilitation and reintegration of drug abusers. The National Council on Drug and Alcohol Abuse, an advisory body was established, in Zimbabwe in 1987.

8.2 Programme evaluation

The 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987) suggested that legislation on the treatment of drug- and alcohol-dependent persons should have several objectives, including the establishment of a complete and ongoing system of accounting and evaluation of the results achieved by a treatment programme and of a system of periodic reporting back to the legislature on its progress. Also essential in new or improved legislation is the designation of an agency or agencies responsible for the treatment programme. As noted in a previous study (Curran, Arif & Jayasuriya, 1987), the only part of the programme which might not be placed formally under the authority of the designated agency, especially if it is a subdivision of a ministry of health, or comes under a national drug and or alcohol control and treatment board, is evaluation. This might better be located in a broadly oriented planning office of the ministry or board so as to ensure its independence. The same may also apply to the epidemiological and other research and data-collection services, which could suitably be integrated with other such services in the ministry or board.

Our current international survey reveals that the type of advisory or coordination bodies with evaluation duties varies from country to country, as noted in Table 2.

Table 2
Advisory and coordination bodies responsible for evaluation

Country	Advisory and coordination body
Australia	National Drug Strategy
China	Narcotics Expert Committee
Mexico	National Council of Health
Philippines	Dangerous Drug Board
Poland	Commission for Counteracting Alcoholism
Spain	Each ministerial department concerned (e.g. Foreign Affairs, Education and Science, Culture, Home Affairs, Justice, Health and Consumption, Labour and Social Security)
Togo	Interministerial Commission

It was pointed out in the 1986 WHO survey (Porter, Arif & Curran, 1986) that accountability and evaluation are critical to the assessment of programme effectiveness and that formal public accountability for treatment policies and programmes must be established at the various levels of policy development and implementation. In this earlier study, a lack of adequate evaluation criteria was found in the legislation surveyed. This is a major deficiency, and several examples of different but exemplary ways that national and subnational jurisdictions have established evaluation criteria are therefore presented in the materials which follow for use as a guide in establishing evaluation programmes.

In spite of this legislative deficiency, coordinating and advisory bodies have provided mechanisms for accountability and evaluation of programmes and policies. For example, the terms of reference of the China Hong Kong Action Committee Against Narcotics (ACAN) Sub-committee on treatment and rehabilitation are exemplary in establishing review mechanisms (Hong Kong, 1993):

> Action Committee Against Narcotics Sub-committee on Treatment and Rehabilitation
> Terms of Reference:
> To make recommendations to ACAN on:
> 1. the treatment and rehabilitation of drug addicts;

2. proposals for the development, expansion, and/or modification and co-ordination of treatment and rehabilitation programmes, whether undertaken by government departments or voluntary agencies;
3. research activities.

Evaluation activities include, in 1999, the ACAN Research Sub-Committee commissioning of two research projects: (1) comprehensive study of chronic drug abusers, methadone patients in particular; and (2) a study on the motivation of early drug users to enter treatment (Hong Kong, 1999a).

Evaluation is meaningless unless goals are measurable. However, legislative objectives and programme plans often do not include measurable goals. As urged in the 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987), it is sound policy for treatment programmes to develop effective working relationships with legislative assemblies, for the purpose of developing channels of communication and effective cooperation.

The present international legislative survey revealed different national legislative requirements for the evaluation and analysis of treatment centres, as follows:

- broad hospital reform legislation (e.g. France);
- specialized legislation on drug treatment and rehabilitation (e.g. Venezuela);
- specialized legislation on combined alcohol and drug treatment and rehabilitation (e.g. Canada (Prince Edward Island));
- specialized (time-limited) legislation on preventing drug dependence and improving living conditions of drug dependent persons (e.g. Switzerland);
- specialized legislation, in federal countries, on determining the most effective forms of treatment (e.g. United States of America).

In France, Law No. 91-748 of 31 July 1991, which concerns broad hospital reform, requires health establishments, whether public or private, to develop a policy for the evaluation of professional practices, the modalities for the organization of care, and any measure that contributes to the comprehensive assumption of care for the patient, for the purpose of assuring quality and efficiency. Moreover, both public and private health establishments must analyse their activities and establish systems of information that take into account the procedures for assumption of care, for the purpose of improving knowledge and the evaluation of the activity and the costs entailed, and of fostering the efficiency and optimization of care. The French National Agency for the Development of Medical Evaluation must contribute to the elaboration, validation, and implementation of the methods and the dissemination of the results of experimentation, and to the training of professional personnel.

In Venezuela, resolution No. G-1112 of 16 June 1988 requires the preparation of reports on the activities of treatment and rehabilitation centres for drug-dependent persons and potential drug users. In Switzerland, the Ordinance of 21 October 1992, which remained in force until 31 December 1996, required the Confederation to support the evaluation of measures to prevent drug dependence, improve the health status of drug-dependent persons and their living conditions, reintegrate such persons into society, and reduce delinquency associated with narcotics. The purpose of the evaluation was to provide scientific data enabling preventive and care measures to be selected and improved so as to reduce drug-dependence-related problems. The ultimate objective of preventive and care measures was to lead drug-dependent persons towards abstinence. Up to five trials for the prescribing of heroin were to be conducted, limited to 50 drug-dependent persons per trial. A trial is defined in the Ordinance as "a project providing for the medical prescription of narcotics other than orally taken methadone". The legislative purpose of the trials was "to measure the success of a treatment as a stage towards abstinence" based on the following criteria: (*a*) improvement of the physical and/or mental state of health; (*b*) improvement of social integration (development of working capacity, removal from the "drug scene", reduction of delinquency); and (*c*) development of a sense of responsibility as regards the risk of infection by human immunodeficiency virus HIV.

The Ordinance provides that a trial must be stopped when it contravenes the legislation in force or the guidelines of the Swiss Academy of Medical Sciences concerning experimental research in humans.

The prescribing of heroin for drug- dependent persons has many implications for policies, legislation and programmes. The inclusion of specific provisions, as in the Swiss Ordinance, requiring the trial to be stopped when it is in conflict with the law or with scientific guidelines provides flexibility and may blunt criticism. The use of a so-called "sunset provision" requiring the experiment to end at a certain time, namely 31 December 1996, is also an apparent wise strategy as it means there may be sufficient time to make the needed evaluations while assuring policy-makers and the public that the trial will come to a definite end, without need for the enactment of additional legislation.

Public Law 99-570 of 27 October 1986 (Title IV - Demand Reduction, 42U.S.C. 300y-2) of the United States of America (Federal) - the Anti-Drug Abuse Act of 1986 - provides that 1% of the funds appropriated under the provisions of the Act are to be used to determine the most effective forms of treatment for alcohol and drug abuse. Moreover, the Federal Government must assess the comparative effectiveness of various forms of treatment for specific patient groups. In Canada (Prince Edward Island), the Addiction Services Act, dated 24 April 1981, provides that the Minister of Health and Social Services has overall responsibility for the planning, coordination and delivery of programmes relating to alcohol and drug abuse in the province. The Minister is given the power under the Act to:

(a) establish minimum standards for the operation of treatment centres and set rules and procedures for the admission, care, treatment, rehabilitation and discharge of alcoholics and drug abusers and for the administration of medication to such persons;

(b) evaluate addiction programmes on a continuing basis and inspect treatment centres.

In communications among policy, legislative and programme planners, the need for realistic planning should be kept clearly in mind. The WHO Expert Committee on Drug Dependence in its twenty-eighth report, covered the need both for planning, and evaluation (World Health Organization, 1993c), as follows:

> As already stressed, the harmful use of drugs and dependence pose complex problems for many sectors of the health and social services. Whatever the national level of development, an optimum deployment of available resources to meet this situation will be achieved only by careful planning. This implies the establishment of an epidemiological base, the assessment of needs, the setting of targets and priorities, and the establishment of evaluation and monitoring activities. At both national and local level, the planning of responses to drug-related problems should not only be integrated with general health and social care, but should also involve other sectors.

The Committee (World Health Organization, 1993c) also discussed the subject of what can be expected of treatment, and emphasized that individual drug users, their families, health professionals, planners and communities need to understand what can and cannot be expected from the treatment of dependence and other drug-related problems. The Committee also emphasized that, if a balanced and informed view is not established, there will be a risk of either too great optimism or unfounded pessimism. Other subjects covered by the Committee in this connection were the essentials of the treatment process, the need to take a long term view of treatment, and the concept of harm minimization. These subjects are more fully discussed elsewhere in this publication.

In the United States of America, the Substance Abuse and Mental Health Services Administration (SAMSHA), is concerned with services.[18] The National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse, which are concerned with research, are part of

[18] Participants at the Harvard Advisory Group meeting addressed the funding, monitoring and evaluation aspects of national and subnational treatment and rehabilitation programmes, essentially in relation to the situation in the United States. This paragraph states the main elements of a paper presented at the meeting by Dr Mary A. Jansen (M.A. Jansen, unpublished observations, 1994).

the National Institutes of Health, under the Department of Health and Human Services. SAMSHA is interested for the most part in testing new approaches to treatment services, conducting research aimed at developing new treatment modalities, and providing funds for direct services at the state level. Evaluation in the United States of America is frequently linked to funding as a requirement for receiving support. In the substance-abuse field, evaluating the effectiveness of drug treatment is often a complex undertaking because of the population groups involved, patterns of addiction, and other factors[19]. In a country as large as the United States, funding for substance-abuse treatment and rehabilitation is very complex, and it is widely acknowledged that there are not enough public funds to meet needs. However, public funding for state-level grants has increased in the United States to provide more treatment placements and facilities for those persons with the most severe drug problems[20]. Also in the United States, under the (Federal) Alcohol and Drug Abuse Amendments of 1983, the Department of Health and Human Services is authorized to make grants to universities, hospitals, laboratories, and other public or non-profit-making institutions and individuals, giving special consideration to projects relating to the comparison of the cost and effectiveness of various treatment methods for alcoholism and alcohol abuse, and the effectiveness of prevention and intervention programmes for such abuse.

The Advisory Group participants expressed encouragement for the new (Federal) efforts in the United States to improve support for treatment and rehabilitation services in the states and at the community level. There is a need in many countries for this type of national-level support, with national legislation indicating public commitment to provide comprehensive and effective treatment and rehabilitation services for alcohol- and drug-dependent persons.

Standards for the accreditation of centres for social and health care for drug-dependent persons were found in the legislation of Spain (Asturias), and the Philippines. Legislation on the conditions and requirements to be fulfilled by centres for social and health care for drug-dependent persons, and on the criteria to be met by applications to set up clinics for inpatients or outpatients was found in Spain (Asturias), Thailand, and Uruguay. Legislation on the functions of physicians in curative and preventive care establishments under the jurisdiction of municipalities was identified in Hungary.

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[19] See Chapter 7 (7.2.2) noting the establishment by 2002, in the United States of a National Treatment Outcomes Monitoring System (NTOMS) to track the effectiveness of treatment in all public and private sectors of the substance abuse treatment system (United States, 1998b).

[20] The Office of National Drug Control Policy (ONDCP) in its 1998 Strategy reports that providing treatment for chronic drug users in the United States is both compassionate public policy and sound investment. For example, ONDCP cites a drug abuse treatment outcome study by the National Institute on Drug Abuse that outpatient methadone treatment reduced heroin use by 70 percent, cocaine use by 48 per cent, and criminal activity by 57 percent, thus increasing employment by 24 percent (United States, 1998a).

8.3 Cost and value of treatment

Two recent studies conducted in the United States of America addressed the effectiveness and costs of drug and alcohol treatment. One study (National Opinion Research Centre and Lewin-VHI, Inc., 1994a)[21] was designed to show, for the State of California, the effects of treatment on participant behaviour; the costs of treatment; and the economic value of treatment to society.

The Director of the California Drug and Alcohol Treatment Assessment reported that the results showed that:

1. Treatment is very cost beneficial to taxpayers, averaging US$ 7 return for every US$ 1 invested.
2. Criminal activities significantly declined after treatment. As an example, the study revealed that in 1992 the cost of treating approximately 150 000 persons was US$ 200 million. The benefits received during treatment and in the first year afterwards totalled approximately US$ 1.5 billion in savings, with the largest savings due to reductions in crime.
3. Significant improvements in health and corresponding reductions in hospitalizations were identified during treatment and after treatment. It was observed, for example, that emergency-room admissions were reduced by one-third during treatment.

A study (Rand Corporation, 1994a) conducted by the Rand Corporation for the United States (Federal) Office of National Drug Control Policy and the United States Army, compared the effectiveness of supply-reduction and demand-reduction programmes in controlling cocaine. A companion study (Rand Corporation, 1994b), also by the Rand Corporation, covered modelling the demand for cocaine. The conclusion reached was that the treatment of heavy cocaine users is more cost-effective than supply-control programmes. The authors discuss this conclusion in the light of the conventional perception that treatment does not work.

Two explanations are offered, the first being that evaluations of treatment typically measure the proportion of persons who no longer use drugs at some point after completing treatment. Consequently, the benefits of keeping people off drugs while they are in treatment are under-appreciated. The authors conclude that roughly one-fifth of the consumption reduction generated by treatment accrues during treatment. The second explanation is that about three-fifths of cocaine users who start treatment stay in their programme for less than three months. Because such incomplete treatments do not substantially reduce consumption, the report notes, treatment looks

[21] An executive summary is also available (National Opinion Research Centre and Lewin-VHI, Inc. 1994b).

weak by traditional criteria. Since treatment does not cost much, incomplete treatment does not dilute the cost-effectiveness of completed treatments. It is estimated that treating all heavy users once each year would reduce United States consumption of cocaine by half in 2007 and by less than half in earlier years.

9. Applied principles of legislation on drug and alcohol dependence

A treatment programme for drug or alcohol dependence gains appreciably by being supported by effective national legislation which helps to achieve for it the national priority that these extremely serious public health problems demand. Treatment programmes must be planned to meet the specific needs of each country. Legislation establishing such programmes, if not enacted and interpreted in accordance with the actual programmes of the country concerned, can disrupt services and create difficulties in programme implementation. Differences in tradition and culture, religious beliefs, available facilities and manpower resources, as well as budgetary constraints make it necessary to suggest different approaches to providing and improving national services (Porter, Arif & Curran, 1986).

The present international survey revealed that most respondents believe that national legislation facilitates the development of programmes for the treatment and rehabilitation of drug- and alcohol-dependent persons.

9.1 Does legislation help or hinder the development of programmes?

We asked respondents to say whether, in their opinion, legislation facilitates or hinders the development of programmes for treatment and rehabilitation, and if so how. Their responses are summarized below:

Legislation hinders the development of treatment and rehabilitation programmes for the following reasons:

- restriction of methadone services;
- punitive nature of criminal law discourages treatment;
- not all sectors adequately implement the legislation;
- legislation is outdated and needs reform;
- medical opinion should be considered;
- there are sometimes gaps in the regulations;
- voluntary admission is preferred;
- legislation should be specific to drug abuse;
- court review and medical examination are perceived as impediments;
- lack of adequately developed legislative system;
- regulatory reforms are needed.

Legislation facilitates the development of treatment and rehabilitation programmes for the following reasons:

- it establishes funding priorities;
- even with legislation, adequate and appropriate funding and distribution are key elements;
- only when it is implemented;
- by laying down principles but not prescribing details;
- by bringing in economic resources and professional guidelines;
- by setting requirements, standards and proper directives;
- when it establishes a basis for additional regulations;
- by recognizing the special characteristics of drug and alcohol problems, as compared to other health problems;
- it unifies treatment and rehabilitation policies at country level, for the orderly delivery of services;
- by means of liberal provisions for voluntary treatment; while also providing for compulsory treatment;
- by promoting new treatment programmes and encouraging the work of existing facilities through supervision;
- by providing flexibility, e.g. enabling methadone maintenance programmes, or recognizing and enabling different approaches within a national scheme;
- when backed up by policies, administrative actions and funding to develop a framework for treatment;
- by establishing and providing guidelines for therapists;
- by promoting community based programmes;
- by helping to create an orderly transition when there is fundamental political and economic change;
- by stimulating self-help groups;
- by enabling the financing of after-care rehabilitation services;
- by establishing after-care facilities;
- by serving as a starting point to rally and organize efforts for treatment programmes;
- by designating other sectors for the delivery of services;
- previously hindered, now facilitates;
- legislation and regulations are quite comprehensive and have stimulated the development of programmes; treatment and rehabilitation are given special emphasis;
- the separation of alcohol- and drug-treatment facilities along with the installation of specialized services is important for many reasons, one being that drug addicts do not regard themselves as ill persons, or consider the need for treatment;
- recently installed referral system needs to be strengthened because, although a variety of alternatives to treatment are available, drug-dependent persons do not necessarily receive treatment tailored to their specific needs.

Some respondents considered that legislation neither facilitates nor hinders the development of treatment and rehabilitation programmes, and made the following comments:

- facilitates in some areas and hinders in others;
- reflects a discredited medical approach.

Other opinions expressed were as follows:

- distinction between treatment and rehabilitation creates a barrier to planning and the realities of drug abuse in some countries;
- barriers are mostly financial not legal;
- in practice, legislation is almost irrelevant; more influenced by local councils;
- essentially, socioeconomic factors determine treatment effectiveness.

9.2 Model of what a statutory system should contain

In the 1977 WHO publication on harmonizing objectives in mental health law (Curran & Harding, 1977) it was noted that a critical review of the mental health legislative programme of a country would be aided greatly by first constructing a model of what a complete statutory system should contain in order to function properly. A similar approach was adopted in the 1986 WHO survey publication (Porter, Arif & Curran, 1986) and we have used the same approach here, and assumed the same basic statutory structure, as follows:

1. *Policy*	Establishment of broad public policy and objectives in the drug- and alcohol-dependence treatment programme.
2. *Authority*	Designation of proper authority for planning and carrying out the public policy and administering treatment programmes for drug and alcohol dependence (along with other health programmes of a public nature).
3. *Budget*	Outline of budgetary policy and provision of continuing fiscal support for publicly conducted treatment programmes for drug and alcohol dependence.
4. *Operations*	Provision of adequate structure for, and details about the operation of, treatment programmes for drug and alcohol dependence to enable administrators to follow and to implement.

5. *Research, training and education*	Provision of central planning (and financing to the extent determined) for research on the treatment of drug and alcohol dependence and for the education and training of qualified personnel.
6. *Entry to services*	Provision for equitable, non-discriminatory entry to treatment programmes for drug and alcohol dependence and access to services.
7. *Protection of individuals*	Provision of protection by the law and through legal-judicial institutions (courts, tribunals, etc.) of the rights, welfare, property, and dignity of persons especially those subject to compulsory reporting, registration, testing, surveillance and confinement for treatment.
8. *Minimum standards for manpower and resources*	Establishment of the policy for minimum standards (in such detail as may be deemed necessary and desirable) for treatment programme manpower and resources, including regulation of professional competence and adequacy of treatment facilities.
9. *Regulation of treatment methods*	Establishment of the policy for regulating the methods and procedures used in the treatment programme, including clear statutory definitions of persons eligible for treatment, grounds, release, etc.
10. *Accountability and evaluation*	Provision of a complete and ongoing system of treatment programme accountability and evaluation.
11. *Delegation of regulatory powers*	Delegation of authority, within statutory limits, from the legislature to governmental agencies (such as public health authorities) to adopt administrative regulations, decrees, or other legal instruments, for further implementation of legislative policy, to apply technical detail to the programme, and to be able to adjust the content of the programme to changes in conditions in the field.
12. *Definition of terms*	Precise definition of major terms used in legislation.

9.3 Policy

Official government policies established by the executive branches of government have been reviewed in Chapter 7. In what follows, we examine the "policy" of parliaments and legislatures as found in the statutes and legislation which they enact. This policy is sometimes termed "legislative intent", and may not be consistent with the policies of the executive branch of government. Of course, the coordination and compatibility of both the executive and legislative branches (or similar systems) are essential if effective programme services are to be provided.

Political, economic and social changes have occurred in many parts of the world in the 1980s and 1990s. Many governments are struggling to meet the obligations of the conventions, and to enact the new policies and legislative provisions which changed circumstances require and the public demand. There is a need for legislation that is both comprehensive and appropriate. In some countries, legal systems are undergoing profound changes. New and sometimes comprehensive legal codes, environmental laws and public health provisions are in the early stages of development. This is true particularly in commercial and economic development, where the goals are to enable countries to develop and sustain market economies, and to compete and trade multinationally.

9.3.1 *Countries with little new specialized legislation*

Sometimes, as we found in China, requirements and responsibilities concerning substance-abuse treatment and rehabilitation are not explicitly included in public health laws or in specialized legislation and regulations on drug abuse. For example, we found that the Decision of the Standing Committee of the National Peoples Congress on Drug Ban (approved by the Committee at its seventeenth session on 28 December 1990 and proclaimed by Decree No. 38 of the President of the People's Republic of China on the same date) requiring that persons "addicted to drugs shall be forced to give up and receive treatment and education" contains the only legislative or regulatory provisions pertaining specifically to drug- or alcohol-dependence treatment or rehabilitation in China.

9.3.2 *Countries with more recent specialized legislation*

Other countries have made many recent changes to existing legislation affecting both drug- and alcohol-dependent persons. Such changes have reportedly resulted in the release of many persons from compulsory or restrictive treatment settings.

In the Russian Federation, for instance, several new laws have been enacted, and we have received a report and a commentary on these laws from a country-level respondent (V.E. Pelipas, personal communication, 1994), the principal elements of

which are presented as follows. The Resolution of 22 July 1993 of the Supreme Soviet, as previously mentioned in Chapter 7, sets out the principles of State policy in regard to narcotics control. The aim of this policy must be to provide a balanced set of measures to prevent the illicit trade in narcotics and reduce demand. It must be based on the following principles: improvement of the procedures for regulating the legal distribution of narcotics; control of illicit trade; prevention of illicit use of narcotics; and treatment and social rehabilitation of drug addicts. Concerning alcohol abuse, in accordance with the Order of the Presidium of the Supreme Soviet of the USSR on strengthening measures to combat drunkenness, dated 16 May 1985 (acceded to by the Russian Federation, and in force), State policy has been to introduce measures restricting alcohol consumption by reducing production and sale, and by creating an atmosphere of intolerance of alcohol abuse. Moreover, pursuant to the Decree of the Supreme Council of the Russian Federation dated 21 June 1993 (implementing the Russian Federation Law on Institutions and Organs Executing Criminal Punishments in the Form of Imprisonment), as of September 1994, all persons were released who had been involuntarily committed to labour institutions under the 1967 Order of the Presidium of the Supreme Soviet of the USSR on compulsory treatment and labour re-eduction of alcohol addicts. Decree No. 959 of 1993 on Measures for Improving the Maintenance of Public Order in Streets of Russian Federation Cities and Other Settlements provides for the establishment of rehabilitation centres, social refuges, night shelters, and other public institutions for alcoholics and drug addicts. 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 came into force on 1 January 1993, (V.E. Pelipas, personal communication, 1994).

9.3.3 *Reconciling the objectives of law enforcement and treatment*

One of the major problems associated with drug dependence is the difficulty of reconciling the policy objectives of law enforcement and those of treatment programmes. As noted in the previous WHO survey (Porter, Arif & Curran, 1986), this conflict is less marked in respect of alcohol dependence, especially in countries where the policy of decriminalizing public intoxication has been adopted. As urged in the WHO guidelines (Curran, Arif & Jayasuriya, 1987), it would be a dangerous mistake, in determining national policy on the treatment of drug and alcohol dependence, to dismiss the importance of prevention and control through law-enforcement programmes. Some degree of "decriminalization", however, and especially the avoidance of very severe criminal penalties for clearly dependent sick persons, can help to encourage such persons to seek early treatment and rehabilitation. It is not advisable, however, to try to achieve the complete decriminalization of all conduct related to trafficking in, and profiting from, the illicit distribution of dangerous drugs.

In most subnational (state) jurisdictions in Australia, (D. McDonald, personal communication, 1994), state drug-control legislation results in drug-dependent persons who use drugs receiving treatment primarily through the diversion treatment

programmes of the criminal justice system. We are also informed that all states in Australia have legislation whereby the courts and the police are authorized to divert drug-dependent persons who use drugs to services outside the criminal justice system. In Australia, the National Drug Strategic Framework 1998-1999 to 2002-2003 calls for improving access to treatment for people in the criminal justice and juvenile justice systems, including expansion of diversion programs to enable those apprehended for minor drug-related offences to be provided a range of treatment services. (Australia, 1998).

However, in some jurisdictions, such as India, it is reported (P.S. Gopinath & J. Rao, personal communications, 1994) that, although the Narcotic Drugs and Psychotropic Substances Act, 1985 contains provisions authorizing diversion to treatment services, the Act is considered predominantly punitive in approach, as its main goal is to effectively control drug trafficking. Moreover, diversion of offenders into treatment is considered to be a long drawn out process. One respondent (Institute of Mental Health, Hunan Medical University, unpublished observations, 1994) in China opined that the legislation might hinder the development of treatment and rehabilitation programmes because of the overemphasis on the illegality of drug abuse and the neglect of other aspects, and might thus contribute to the onset and development of drug abuse. Similarly, in Madagascar, a respondent considered (C. Ralambo, personal communication, 1994) that legislation and regulations hinder the development of treatment programmes because the criminal provisions prevent effective contact with, and approach to, drug-dependent persons at health-care services.

9.3.4 *Reform of health legislation*

As previously noted, in many countries, health legislation is in process of development and reform. A respondent (J. Strazdins, personal communication, 1994) in Latvia, for instance, considers that all the government orders before 1990 hindered the development of therapy, but that at the time of writing (1994) each medical-care facility was able to draw up its own individual action plan, and to strive for high-quality services. This is because the payment of medical professionals now depends on the effectiveness of therapy. It is also reported (J. Strazdins, personal communication, 1994) that patients may themselves choose which clinics and physicians to go to.

9.3.5 *Preamble to the legislation*

The WHO guidelines (Curran, Arif & Jayasuriya, 1987) note that a preamble to, or statement of purpose in, legislation should include the following: (*a*) an indication of the problems that the legislation seeks to remedy; and (*b*) the main purposes of the legislation. The preamble should state the intent of the parliament or legislature that enacted the provisions. In addition, it can set out how the legislation fulfils new national political objectives.

For instance, in the preamble to Constitutional Law 1/1988 of 24 March 1988 amending the Criminal Code in Spain, a major new measure is introduced, namely that courts are empowered to order suspended sentences with detoxification treatment for "drug addicts who commit an offence so as to meet the needs of their addiction". The preamble encourages the law-enforcement authorities to support treatment personnel in the implementation of its provisions. It also alerts the reader to the new public health problems that legislators seek to address in the Law, the purpose and scope of its provisions and the services that are to be provided.

In the Hal S. Marchman Alcohol and Other Drug Services Act of 1993 of the United States of America (Florida), legislative findings, intent and purpose are set out in the first section (Section 397.305) of the Act. The scope of the Act is readily apparent because the announcement in this Section states that substance abuse is a major health problem that leads to profound consequences, such as chronic addiction, criminal behaviour, business losses, learning disabilities in children, and spiralling health-care costs. The Act also states that AIDS is a consequence of substance abuse, so that a specific public health problem is identified as a focus of legislative concern and action.

9.4 Designation of the responsible agency

As pointed out in the 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987), it is essential in legislation providing for treatment and rehabilitation programmes to designate the responsible agency or agencies. The designated agency should be identified in the legislation itself and: (i) be directed to coordinate the comprehensive programme of treatment, rehabilitation, community and patient education, and epidemiological and other scientific research outlined in the preamble or statement of purpose; (ii) be required to collect the data needed in order to determine where the available resources can best be utilized; and (iii) be directed to cooperate with other public bodies, such as law-enforcement agencies and national drug and or alcohol control boards. Each country will, of course, select the most appropriate agency or agencies for this purpose. Whatever the agency selected, the aim should be to centralize the leadership of the programme and to ensure effective coordination of treatment services.

9.4.1 *Types of legislation*

Two types of legislation designating a specific agency to be responsible for treatment are reviewed here: (*a*) legislation creating a new department consolidating public health and dependency services; (*b*) legislation for the control of narcotic drugs and psychotropic substances and for the treatment of those dependent on them.

(*a*) Agency consolidating public health and dependency services

In the United States of America (Connecticut), Public Act No. 93-381, dated 1 July 1993, establishes a new Department of Public Health and Addiction Services under the direction of a commissioner responsible to the Governor, the highest elected authority in the State. This Act requires the Department to encourage the establishment of subregional planning and action councils which must determine the extent of the substance-abuse problems within their subregions; determine the status of resources to address such problems; identify gaps in the substance-abuse service continuum; identify changes in the community environment that will reduce substance abuse; design programmes that will fill identified service gaps and reduce substance abuse by changing the community environment; and develop and implement a plan to close such gaps. Membership of such councils must include the chief elected official, the police chief, the superintendent of schools, representatives from each treatment facility operated by the Department; business and professional leaders; members of the legislature; substance-abuse service providers; representatives of minority populations; religious organizations; representatives of private funding organizations; and the media. Each council must submit annual plans including estimates of the extent of substance abuse within the subregion; identifying gaps in the substance-abuse continuum; activities for the coordination of prevention, intervention and treatment within the subregion; activities to develop programmes that fill identified gaps in the services; and activities to develop and implement changes in the community environment that will reduce substance abuse.

(*b*) Control of narcotic drug and psychotropic substances

In Bangladesh, the preamble of the Narcotics Drugs and Psychotropic Substances Control Act, 1990 states that it is expedient to provide for the control of narcotic drugs and psychotropic substances, and for the treatment and rehabilitation of drug addicts. A Narcotics Control Board, made up of representatives of the Ministry of Health and numerous other ministries, is established by the Act to fulfil its objectives. It is responsible for coordinating all anti-narcotic activities, including the establishment of policies for the treatment and rehabilitation of narcotics addicts, and the implementation of those policies. The National Narcotics Control Board Fund established under the Act may be a "separate fund", i.e. funds may be collected in addition to the usual budgetary allocations for use in prevention and in the treatment and rehabilitation of narcotic addicts. A Department of Narcotics Control is also established for the purpose of implementing the Act.

9.4.2 *Designation of the agency responsible for funding*

In Pakistan, The Control of Narcotic Substances Ordinance, 1996, dated 2 November 1996 provides that the Federal Government and Provisional Government shall bear all expenses for first time compulsory detoxification and de-addiction of an addict.

In the United Kingdom, it is reported (J. Waterson, personal communication, 1994) that the transfer of funding through individual income-support mechanisms, via the Department of Social Security, to local authority social service departments, has in many instances hindered the development of rehabilitation services. Voluntary providers, unless contracted to provide a specific volume of services and in receipt of a guaranteed income, are unable to respond flexibly to need. Similarly, as local authorities have taken over the role of purchasing services, voluntary agencies have become less innovative and more dependant on winning and securing local authority funding for specific services.

9.5 Budget

Budgetary and fiscal support for public treatment and rehabilitation programmes are essential to the effective execution of such programmes. Despite enlightened policy and legislative formulation, financial considerations often determine the success of treatment and rehabilitation programmes. For instance, our current survey reveals that, in many countries (e.g. Brazil, Poland), while legislation facilitates the development of treatment programmes, they are not implemented fully in practice, due mainly to lack of resources. In the United Kingdom, it is reported that the predominant constraints on programme development are fiscal rather than legal (D. Cameron, personal communication, 1994). Reductions in health service expenditures and the move towards standardized treatment packages have reportedly reduced the ability to tailor treatment according to individual needs (J. Waterson, personal communication, 1994).

9.6 Operations

As recommended in the 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987), details of the day-to-day operation of a treatment (or rehabilitation) service should *not* be specified in full in the primary legislation. The legislation should, however, authorize the delegation of regulatory powers (see section 9.13) to the agency responsible for the operation of the treatment programme in order to ensure that it is modified and improved in line with new demands on it and to take account of technical and scientific advances in the field. Thus experience in Austria (I. Erlacher, personal communication, 1994) showed that, when legislation and directives only lay down principles but do not prescribe details, they serve their purpose, and do not hinder the

development of new programmes. On the other hand, programmes that do not contain minimum principles should not be authorized by the Minister of Health.

9.7 Research, training and education

Programme planning should be linked to support for research and personnel development. The 1986 WHO survey (Porter, Arif & Curran, 1986) emphasized the importance of research in the evaluation of alcohol and drug programmes, and stressed that sufficient funds should be made available to support both basic and applied research. Legislatures frequently give low priority to requests for support for research and training. Thus, in Mexico, very little research in relation to treatment is carried out; and little is known about: (*a*) the pathways to care; (*b*) the results of the different methods of treatment when applied to users with varied needs; and (*c*) the cost-benefit ratios of the different methods.

Our current legislative survey reveals that, in Venezuela, Resolution No. G-1112 of 16 June 1988 lays down specific rules applicable to treatment and rehabilitation centres for drug-dependent persons and potential drug users. The objectives of the centres are to offer the therapeutic options necessary for the patient's improvement, as well as reintegration into the family and social environment. The centres must:

- provide integrated care to all persons who come to such an establishment requesting clinical care, in order to overcome the problem of drug dependence;
- provide guidance, care, and treatment to families who come to the centre because one of their members is a drug user;
- carry out research activities in the field of drug dependence; and
- evaluate the corresponding action programme.

The Resolution also provides that public and private establishments for the treatment and rehabilitation of the persons concerned must be supervised by psychiatrists or clinical psychologists with experience in the field of drug dependence and training in public health.

9.8 Entry to services

The type and quality of treatment and rehabilitation services provided, and the substantive legal provisions and procedural practices applicable to admission into the treatment and rehabilitation systems are of vital importance in connection with the potential loss of liberty authorized in laws both on compulsory civil commitment and on treatment associated with the criminal justice system. The WHO guidelines emphasize (Curran, Arif & Jayasuriya, 1987) that legislation should ensure equitable

non-discriminatory access to treatment services located close to the patient's own community.

In Finland, under the Act on Welfare for Alcoholics and Drug Addicts, 41/86, services are provided as needed, differences in individual treatment needs and locality being taken into account. Consequently, access to, and level of, services vary in different parts of the country. In principle, it is reported (J. Eskola, personal communication, 1993) that the legislation on state subsidies ensures the equal development of the services; in fact, however, the municipality needing the services defines its service level in relation to the available resources. In the United Kingdom, the major trend in treatment has been away from specialist inpatient units towards community-based provision (D. Cameron, personal communication, 1994.)

9.9 Protection of individuals' rights

Basic safeguards are necessary to protect the rights of individuals deprived of personal liberty during compulsory treatment or imprisonment. Provision for specific and appropriate measures should therefore be made in national legislation to bring it into line with the international human rights conventions. Consideration should therefore be given to providing the same protection to substance abusers as are accorded by law to mentally ill persons, whose liberty may also be restricted during compulsory treatment. In addition, protection of individual liberties should not be denied to disabled persons solely because their disability is due to substance abuse.

The subject of individual rights and responsibilities is more fully reviewed in Chapter 14.

9.10 Minimum standards for manpower and resources

These are important components of treatment and rehabilitation systems, and both government and private organizations may be responsible for setting standards. For example, in Argentina, Joint Resolution No. 160 of the Ministry of Health and Social Action and No. 3 of the Secretariat for Planning Drug Addiction Prevention and Narcotic Traffic Control of 11 May 1995, sets out requirements of care establishments, responsible for the admission, diagnosis, reception guidance, detoxification, rehabilitation, and re-integration of drug-dependent persons of both outpatient and inpatient systems. In order to gain authorization, requirements for technical management and professional staff therapeutic programmes concerning STDs/HIV/AIDS must be met [*IDHL*, 1998, **49** (3)]

One respondent in Greece (C.P. Kokkoris, personal communication, 1994) opined that laws and regulations facilitate the development of programmes for treatment and rehabilitation when they establish requirements and standards for the provision of high-quality services and unified criteria for the evaluation of their

function and cost effectiveness. However, in certain instances, regulations may appear to impose limits and restrictions on medical judgement and diagnosis, thus interfering with the independence of the medical profession within its strict ethical framework, (C.P. Kokkoris, personal communication, 1994).

In Hong Kong Special Administrative Region, it was reported (A. Sinclair, personal communication, 1994) that laws and regulations facilitate the development of treatment and rehabilitation programmes, since they ensure that the standards of the treatment and rehabilitation centres managed by the government and various voluntary agencies are maintained. On the other hand, it is relevant to note that, in Hong Kong, there are 10 voluntary treatment agencies run by religious bodies operating inpatient detoxification and rehabilitation services for drug abusers. They have not sought registration with the Government under the Drug Addiction Treatment Centres Ordinance (Chapter 326, 1989 Ed.) nor do they receive regular Government subsidies. Their services thus provide an option for drug abusers seeking different forms of treatment programmes.

In Hungary it is reported (K. Szomor, personal communication, 1999) that legislation has been enacted establishing operational standards concerning health care facilities, including those designed for substance abuse: *(a)* Decree 2/1994 of the Minister of Welfare on the professional and operational conditions of the institutes offering personal care (social care, counselling, help for families, rehabilitation of drug addicts, therapeutic occupational and social reintegration, employment, professional and methodological prescriptions for the staff); *(b)* Decree 13/1996 on the Licensing for the health care services; *(c)* Decree 161/1996 on the licensing of operation of the social care institutes (including drug rehabilitation, social reintegration services); *(d)* Law CLIV of 1997 on health care (general regulation on treatment, patients rights, accession of services); and *(e)* Minister of Welfare Decree 21/1998 on minimal professional conditions of the health care services (including conditions for drug outpatient clinics).

9.11 Regulation of treatment methods

This relates to the establishment of the policy for regulating the methods and procedures used in the treatment programme, including clear statutory definitions of the persons eligible for treatment, grounds, and release. The minimum standards for manpower and resources (see section 9.10) and the regulation of treatment methods are important components of the regulatory system in the treatment of drug and alcohol dependence. Both governmental bodies and private organizations may be responsible for setting standards. In Ireland, for example, it is reported (B. Sweeney, personal communication, 1994) that the Government has made drug treatment the responsibility of each Health Board area, and local treatment centres are established in accordance with the procedures applicable to other treatment facilities. The powers of the officer in charge of these centres include, e.g. the power to place drug-dependent persons on

treatment lists for methadone maintenance treatment. Each treatment centre has its own treatment procedures and protocols relating to the dispensing of methadone, including urine analysis, full medical and psychological assessment, ongoing medical care and monitoring as well as counselling for patients in such programmes. The dispensing of methadone is carried out under the auspices of, and in conformity with, the regulations of the Pharmaceutical Society of Ireland.

In Zimbabwe, legislation which focuses on prevention is regarded (A. Chidarikire, personal communication, 1994) as a good basis for additional specific regulations and the development of treatment and rehabilitation programmes.

9.12 Accountability and evaluation

The review of legislation requires a proper system of accountability and evaluation, which should be established by the basic law or in implementing legislation. In this regard, the Venezuelan legislation, previously mentioned (Resolution No.
G-1112 of 16 June 1988) provides that the treatment and rehabilitation of drug-dependent persons should depend on the degree of severity of the condition, the degree of intoxication, and the capacity for rehabilitation. The types of treatment and the rehabilitation methods applicable are specified. The social reintegration of drug-dependent persons must be the fundamental objective of the care team. The Resolution also lays down that centres must ensure that the therapeutic process and the social reintegration of the persons concerned continue for a period of at least two years. An evaluation report on the activities of the centres is required every six months. Moreover, pursuant to the Organic Law Governing Narcotic and Psychotropic Substances of 17 March 1984 (see Annex 2.2), the patient's legal representative must make a sworn written statement at the centre in which he agrees to collaborate actively in the treatment of the person he represents. Specific rules applicable to outpatient departments for drug-dependent persons and potential drug users are also laid down. Outpatient services providing medical and psychiatric care to the persons concerned must be equipped with multidisciplinary teams facilitating the care of patients from the biological, psychological, and social standpoints.

9.13 Delegation of regulatory powers

As previously mentioned, the 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987) recommend that details of the day-to-day operation of a treatment service should not be specified in full in the primary legislation. These details may have to be changed frequently, and should therefore be left to the subsidiary legislative instruments, variously called ministerial orders, administrative rules, or departmental or board regulations. Such subsidiary legislative instruments or regulations apply to virtually all personnel and institutions that deliver services for drug- or alcohol-dependent persons, including treatment centres, and cover procedures for the approval

and registration of centres; the qualifications and duties of personnel; the powers of officers in charge; treatment procedures and record-keeping and reporting; and relations with courts and other referral centres.

Subsidiary legislative instruments are generally drawn up and promulgated by the designated agency, which should therefore be empowered clearly and unambiguously to issue the necessary orders or regulations.

As noted in the 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987), some examples of areas that may be covered in ministerial orders or regulations are as follows:

1. Treatment centres:
   - procedures for the approval and registration of centres;
   - qualifications and duties of personnel;
   - powers of officers in charge;
   - treatment procedures and record-keeping and reporting;
   - relations with courts and other referral centres.

2. Standards for professional personnel:
   - educational requirements;
   - experience requirements;
   - authority to prescribe therapeutic drugs;
   - sharing or delegation of authority.

3. Development of primary health care services:
   - involvement of primary health care practitioners;
   - prescribing practices at the primary health care level;
   - links between mental hospitals and the community;
   - involvement of traditional healers.

9.13.1 *Treatment and rehabilitation*

In our survey of regulations we reviewed subsidiary legislative instruments (e.g. regulations, ministerial orders) pertaining specifically to the treatment and rehabilitation of drug- and alcohol-dependent persons.

The jurisdictions having regulatory powers varied among the survey countries. Some countries (Pakistan, Sri Lanka, Zimbabwe) have not promulgated any regulations specific to drug or alcohol treatment or rehabilitation. In some jurisdictions (e.g. Australia, at state level) it is reported (I. Webster, personal communication, 1994) that regulations are not specific to drug- or alcohol-treatment facilities, but are promulgated under those sections of the mental health laws dealing with the approval of general or private hospitals. In Norway, regulatory provisions governing treatment and rehabilitation are reportedly (J.J. Gusland, personal communication, 1994) the

primary responsibility of the county and municipal authorities. In the Netherlands, regulatory authority is reported (I.P. Spruit, personal communication, 1994) to be shared between different jurisdictions, and is found in national, regional and municipal administrative orders. However, some jurisdictions have moved away from using subsidiary regulations to implement legislation. It is reported (J. Eskola, personal communication, 1994) that, in general, Finland has given up the use of regulations as a means of steering administrative actions. Thus the Act on Welfare for Alcoholics and Drug Addicts is considered to be a "framework law", and is applied independently by local authorities; education of the personnel and professional ethics also play a role.

Respondents were asked to specify which regulations or ministerial orders contain specific regulatory provisions pertaining to treatment and rehabilitation, and to harmful use. Survey respondents (from the countries listed) reported that no government regulations or ministerial orders exist in Bangladesh, Bolivia, Hungary, India, Madagascar, Mauritius, and Sri Lanka. Insufficient details were reported in Bolivia (where hospital rules also apply to treatment centres), Brazil and Egypt. In Poland, regulations are formulated at very general level. It was suggested by a respondent (anonymous) working in a clinical psychiatric setting that regulations on treatment and rehabilitation should be drawn up in greater detail and particular concepts defined more precisely.

Regulatory procedures for the approval and registration of treatment or rehabilitation centres varied from one jurisdiction to another. Regulations governing the approval and registration of nongovernmental treatment centres, under the supervision of government health ministries, were reported (A.S. Kamaluddin, personal communication, 1994) in Bangladesh, and (A. Alem Rojo, personal communication, 1994) in Bolivia (see Annex 2.1).

In Austria, it is reported (I. Erlacher, personal communication, 1994) that the Federal Ministry of Health publishes a list of all officially recognized institutions that are authorized to counsel and carry out the treatment of drug addicts. Although currently under revision, in Greece, national regulations (e.g. Regulation A2b1k/3983/87) reportedly (C.P. Kokkoris, personal communication, 1994) govern the organization, function and management of centres for the treatment of drug-dependent persons.

In some jurisdictions (e.g. Mexico) our survey revealed (M.E. Medina Mora, personal communication, 1994) that a series of technical standards have been issued by the Government. These include Technical Standard No. 198 on the provision of medical care for drug-dependence; and Technical Standard No. 197 for the provision of medical assistance to alcoholic patients and individuals with problems related to alcohol abuse. These Technical Standards establish standards for the activities and attitudes of the health personnel of the National Health System in terms of the health care of persons with drug or alcohol problems, including preventive and curative care, and psychosocial rehabilitation, at the different levels of health care. Another

instrument, Agreement A/050/91, establishes the way that "drug addicts" or habitual users must be managed. It provides that if, following an examination and confirmation, it is probable that a withdrawal syndrome exists, emergency measures must be taken to refer the "drug addict" for medical treatment in order to avoid harm.

In the United Kingdom, guidelines for clinical management have been issued (United Kingdom, 1992) containing detailed descriptions of clinical management for professionals working in the field.

Regulations may establish procedures and conditions for the lawful use of potentially harmful drugs. In the United States of America, at the Federal level, the Drug Enforcement Agency and Food and Drug Administration have complementary and shared regulatory authority over the use of medications in the treatment of drug and alcohol abuse. Subnational (State and local) governments also have regulatory authority over the use of medications. In Zimbabwe, regulations establish the procedures and conditions for the lawful use of potentially harmful drugs. In India, it is reported (J. Rao, personal communication, 1994) that the Government may, at its discretion, establish as many centres as it sees fit for the identification, treatment, education, after-care, rehabilitation, and social reintegration of addicts. This also applies to the supply, subject to such conditions and in such manner as may be prescribed, by the Government of any narcotic drugs and psychotropic substances to addicts registered with the Government, and to others for whom such supply is medical necessity. In addition, it is also reported (J. Rao, personal communication, 1994) that the Government may make rules consistent with the Mental Health Act of 1987 providing for the establishment, appointment, maintenance, management and superintendence of, and for the supply of narcotic drugs and psychotropic substances from, the centres and for the appointment, training, powers, duties and persons employed in such centres. However, (as of 1994) no rules had been issued in this regard.

In some federal jurisdictions (United States of America) Federal Regulations (e.g. interim final rule on the Substance Abuse Block Grant, Code of Federal Regulations No. 96) govern the allocation of funds to the various state governments for their use in delivering treatment services. Depending on the type of service, the Federal Government may establish mandatory restrictions of such funds (e.g. prohibiting the use of Federal funds to support needle-exchange programmes) or, alternatively, give full discretionary powers to the states.

In some countries (Kazakhstan, Latvia), legislation and implementing regulations have been reviewed in the light of changing political circumstances. In Kazakhstan, the orders and instructions regulating the organization of treatment services, and the conditions and duration of treatment and observation, which were promulgated by the Ministry of Health of the former Soviet Union, are in still in effect and observed. In Latvia, it was reported (J. Strazdins, personal communication, 1994) that the Latvian authorities had retained the numerous detailed provisions that were

traditional in the former Soviet Union. On 14 June 1990, however, the Board of Health Protection Ministers, issued and adopted Decision No. 7 on Strengthening the Medical and Social Support for Patients Dependent on Alcohol, Drugs and Toxic Substances, under which in- and outpatient care, rehabilitation and social care are monitored (J. Strazdins, personal communication, 1994).

9.13.2 *Treatment centres*

In our survey, we reviewed current regulations on treatment centres: procedures for the approval and registration of centres; the qualifications and duties of personnel; the powers of the officers in charge; treatment procedures and record-keeping and reporting; and relations with courts and other referral centres.

In several jurisdictions (Australia, Ireland, United Kingdom), local area health boards are responsible for regulatory functions. In Ireland, it is reported (M. Lyons, personal communication, 1993) that there is no procedure for formally approving and registering treatment centres. However, the qualifications and duties of personnel in these centres are similar to those of similar personnel at similar levels of responsibility in other Health Board establishments.

In others (Brazil, Costa Rica, Egypt, Portugal), however, commissions, federal councils or committees are responsible for the supervision, approval or registration of centres. In Bolivia, the Regulations of 28 December 1988 (Supreme Decree No. 22099; see Annex 2.1) have been promulgated for the application of Law No. 1008 of 19 July 1988 on the Regime Applicable to Coca and Controlled Substances. Under these Regulations, non-profit-making civil societies, associations and foundation are to be established for prevention, rehabilitation and scientific research, and the National Council against the Abuse of, and Illicit Traffic in, Drugs, is required to develop plans and programmes for the treatment, rehabilitation, and social reintegration of drug-dependent persons. Institutes for treatment and rehabilitation are under the control and supervision of the Ministry of Social Welfare and Public Health. The Health Department is responsible for supervising the functioning of the treatment, rehabilitation and social reintegration centres. The Regulation also provide that no state or private enterprises may discriminate against rehabilitated and socially readjusted persons.

9.13.3 *Standards for professional personnel*

We reviewed standards for professional personnel (e.g. educational requirements; experience requirements; the authority to prescribe therapeutic drugs; and the sharing or delegation of authority). Such standards are often found in subsidiary instruments or regulations.

In Austria, it was reported (I. Erlacher, personal communication, 1994) that, under regulations promulgated pursuant to the Narcotic Drugs Act, 1951, as amended, the authorization of a treatment centre to counsel and care for persons undergoing drug treatment depends on the results of a inquiry conducted by the Federal Ministry of Health. The centre must have qualified professional staff, it must be open at least once a week, and documentation of work and effective cooperation within a network including mental health facilities are also required. In France, Decree No. 98-229 of 29 December 1998 on the centres referred to in Article L.355-1-1 of the Public Health Code, requires that the staff of the outpatient centres for the treatment of alcohol dependence must consist of a multi-disciplinary team of medical and social specialists including a physician in charge of the centre, or at least responsible for the medical activities carried out at the centre, or persons whose qualifications in the field of care and social support are those prescribed by an order of the Minister responsible for Health and Social Affairs [*IDHL*, 1999, **50** (1)].

Several different standards apply to professional personnel. As far as the authority to issue prescriptions is concerned, regulations establish the professional and licensure requirements that must be satisfied. In general, only licensed medical practitioners may issue prescriptions for medicines, but there are significant deviations from this general rule. Thus in Mexico, it is reported (M.E. Medina-Mora, personal communication, 1994) that regulations under Article 1134 of the General Health Law on the Sanitary Control of Activities, Establishments, Products and Services define a medical prescription as the written document that records the prescription. Such a prescription must be signed by a "medical surgeon, doctor, odontologist, registered homeopath, or approved by competent education authorities" and defines the conditions under which medical assistants (undergraduates) and obstetric nurses are allowed to prescribe. The regulations also specify the drugs and pharmaceutical specialties that can only be obtained after official authorization, those that require a medical prescription to be kept in the pharmacy, those that require a prescription that can be filled on more than one occasion, and those that can be obtained over the counter. In Madagascar, it is reported that only physicians who are listed in the national register of physicians may prescribe drugs for medical use (C. Ralambo, personal communication, 1994). In Australia, it is reported (A. Reynolds, personal communication, 1994) that, under the provisions of the Poisons Regulations of 1973, methadone may be prescribed only by licensed medical practitioners. In Ireland, it is reported (B. Sweeney, personal communication, 1994) that drug treatment centres under the control of the Health Boards have medical staff, psychologists, social workers, counsellors and support staff, as in other treatment areas. Record-keeping and reporting is similar to that required for other medical conditions, medical notes being kept on each patient. The courts accept medical reports from such centres, and refer patients for treatment. The centres accept referrals from other treating agencies within the community, but the numbers so accepted are limited by the small number of places available. In Ireland, it is further reported (B. Sweeney, personal communication, 1994) that specialist officers in these centres must satisfy the educational requirements specified for each discipline for working within the Health Board as a consultant,

trainee doctor, or addiction counsellor. Only physicians have the authority to prescribe therapeutic drugs and only consultants are allowed to place patients on the methadone maintenance register (a treatment list kept at the central level). Also in Ireland, however, methadone and other controlled substances are prescribed by general practitioners in the community (B. Sweeney, personal communication, 1994).

9.13.4 *Day-to-day operation of treatment and rehabilitation services*

In some countries, legislation sets out treatment plan requirements. In France, for example, Decree No. 98-1229 of 29 December 1998 on the centres referred to in Article L.355-1-1 of the Public Health Code, provides that each out-patient centre for the treatment of alcohol dependence must prepare a treatment plan which states its therapeutic and medico-social objectives, as well as the procedures for their implementation; the plan must also state procedures for evaluating the activities undertaken, be updated at least every five years and may be revised on the centre's own initiative. [*IDHL*, 1999, **50**(1)]. In our survey, we examined country-level views on whether regulations or ministerial orders adequately set out sufficient details concerning the day-to-day operation of treatment and rehabilitation services.

About one-third of survey respondents (9 of 30) opined that regulations adequately set out the details necessary for daily operations, particularly with regard to methadone maintenance. Some three-fifths (19 of 30) replied that either no regulations existed or, if they did exist, were insufficiently detailed. One respondent noted that treatment regulations did exist, but only for drug treatment, not alcohol treatment. Another respondent in the Netherlands indicated (Jellinek Centre, personal observations, 1994) that regulations did provide sufficient details, but insufficient funding, an opinion widely expressed throughout our survey. Some examples of the responses received are given below.

Where regulations were considered to provide the details necessary for daily operations, the importance of periodic monitoring was emphasized. For instance, in Hong Kong, government officials (A. Sinclair, personal communication, 1994) concluded that existing regulations were adequate; nevertheless, treatment and rehabilitation programmes must be closely monitored, and formal reviews conducted when required.

Both regulations and informal guidelines and procedures are considered to provide sufficient detail for methadone regulations in several jurisdictions. For example, in Australia (New South Wales), guidelines, policies and procedures, as provided by the Drug and Alcohol Directorate, of the New South Wales Health Department, are considered (R. Carbury, personal communication, 1994) generally sufficient for the day-to-day operation of methadone clinics; however, it is further reported that some policies need to be developed at a local level.

In Ireland, it is reported (B. Sweeney, personal communication, 1994) that there is no established protocol for mental health professionals caring for drug-dependent persons other than referral to the National Drug Treatment Centre or to Health Board Special Services for treatment involving either detoxification or the prescribing of substitute substances. Informally, however, general practitioners are prescribing full substitute medication for drug users. It is also reported (B. Sweeney, personal communication, 1994) that, in Ireland, in the AIDS field, a treatment protocol (prepared by a Sub-Committee of the Strategic Committee on AIDS and HIV) recommends treatment procedures for general practitioners and doctors prescribing methadone. This protocol, currently (1994) being considered by the Government, provides clear guidelines on prescribing patterns. The types of drugs which are or are not recommended, as well as the types of services which should be associated with prescribing, including specialist services and rehabilitation programmes, are given in the protocol. There is also a proposal to establish a treatment register, as recommended in the protocol.

In Israel, it is reported (J. Gleser, personal communication, 1994) that regulations provide sufficient detail, but only for drug treatment. Alcohol dependence is covered by the general health provisions. In the Netherlands, regulations on treatment and rehabilitation were considered to be well organized, and well defined at all levels but badly financed, so that there are not sufficient treatment slots for all those seeking treatment (Jellinek Centre, unpublished observations, 1994).

In Mexico, it is reported (M.E. Medina-Mora, personal communication, 1994) that entering into regional and international trade agreements has resulted in changes in regulations, considered by some to be an improvement. For example, it is considered by some observers (M.E. Medina-Mora, personal communication, 1994) that in general terms regulations are insufficient for adequately ensuring the quality of health care and the protection of the public in small private facilities. Consequently, the possibility of signing a free trade agreement with the United States and Canada stimulated the formation of working groups that proposed and validated a new certification system that implies new regulations and an improvement in quality in the provision of services.

In the United Arab Emirates, Ministerial Decision No. 28 for 1987 (regarding internal procedures for addiction treatment unit(s)), dated 25 January 1987, of the Ministry of Health relates to Federal Law No.6 of 1986 on the control of narcotic substances (see note associated with summary of Law No.6, in Annex A2.2). The Decision provides for the establishment of, and by-laws for, drug-addiction units. It covers in detail the supervisory committee on addiction in the treatment unit; the aims of the unit; the duration of treatment; entering and leaving the unit, including voluntary admission, and methods of discharge; rules on visiting; and general rules, including surveillance for safety reasons, inspection requirements, and food restrictions.

In the United Kingdom, apart from covering the prescribing of controlled substances, the regulations do not concern treatment. While not having the force of law, guidelines are sometimes issued which serve similar purposes. For instance, guidelines produced by the United Kingdom Advisory Council on Drug Misuse are advisory in nature (D. Cameron, personal communication, 1994).

In the United States of America, the Federal Regulations promulgated by the Federal Department of Health and Human Services are considered (D. Des Jarlais, personal communication, 1994) by substance-abuse research personnel to be sufficiently detailed for methadone maintenance programmes.

In Zimbabwe, it is reported (A. Chidarikire, personal communication, 1994) that Government regulations give very specific details concerning the supply of potentially addictive drugs in terms of amounts, outlets and records.

9.13.5 *Development of primary health care services*

In our survey, we examined regulations or ministerial orders on the development of primary health care services (e.g. involvement of primary health care practitioners; links between mental hospitals and the community; and involvement of other care givers in the community).

Programmatic and technical "hands on" professional guidance is often of practical use where official regulations are not in place, or not desired. For example, where no regulations are in force, "official" clinical practice manuals may be used. In Bolivia, although there are no specific regulations on primary health care services, specialized staff or personnel exist in some areas who are trained to deal with problems of mental health or drug dependence. Moreover, an official *Manual for health professionals on primary health services, alcohol and drugs*, is reportedly available (M. De La Quintana Rios, personal communication, 1994). In Colombia, a manual of standards and the operational procedures of the treatment network for drug dependence is reportedly (G. De Vega Pinzon, personal communication, 1994) in use.

Advances in primary health care training were reported in India, Iraq, and Pakistan. In India, although no regulations on treatment are in place, it is reported (M.S. Kumar, personal communication, 1994) that the delivery of mental health services is being transferred from mental hospitals to the community under the direction of the National Community Mental Health Programme. In Iraq, primary health physicians and other workers reported that courses in mental health, and in drug and alcohol abuse form part of their training. There is reportedly (I. Al-Adhmawi, personal communication, 1994) good linkage between mental hospitals and community and primary health physicians. In Pakistan, it is reported (M.H. Mubbashar, personal communication, 1994) that the National Mental Health Programme specifies a community-based primary health care approach in which the primary health care

physicians are responsible for the treatment of drug-dependents, referral and the maintenance of records, while health workers provide emergency medical aid and follow-up. Moreover, the psychiatric units of district hospitals and teaching hospitals are reportedly (M.H. Mubbashar, personal communication, 1994) responsible for training and the provision of referral services. Occupational therapy and rehabilitation units have been provided at some of these facilities, but there are no regulations governing the day-to-day operations of these treatment and rehabilitation facilities.

Table 3 shows, for a number of countries the subsidiary legislation on the development of primary health care services and other documents coordinating primary care, community, mental health and other linkages for the treatment and rehabilitation of drug- and alcohol-dependent persons.

Table 3

Specific regulations or ministerial orders for development of primary health care services, or other documents coordinating primary care, community mental health and other linkages[1,2]

Country	Yes	Regulation or Ministerial Orders	No	Other documents
Australia			X	-
Bangladesh			X	-
Bolivia			X	*Manual health professionals on primary health services, alcohol and drugs*
Brazil	*X*	Law to create centres for medical, social and psychosocial care, national division of mental health, Ministry of Health, Brasilia,1991.		
Colombia			X	Manual of standards and the operational procedures of the treatment network for drug dependence
France	X	Circular DGS - DH No.15 of 7 March 1994 and Government plan for control of drugs and drug addiction of 21 September 1993.		-
Greece	X	Decision No.A2b/ik.3981 of 7 October 1987 on counselling, support and treatment programmes		-
Hungary			X	-

Table 3 *(continued)*

Country	Yes	Regulation or Ministerial Orders	No	Other documents
India			X	National Community Mental Health Programme
Ireland			X	-
Israel	X			-
Kazakhstan	X			-
Latvia	X	Decision No.7 of 14 June 1990.		-
Mauritius			X	-
Mexico	X			-
Morocco	X			-
Netherlands	X			-
Nigeria			X	-
Pakistan			X	National Mental Health Programme
Philippines			X	Dangerous Drug Board
Poland	X	Ordinance of the Minister of Health and Social Welfare, 3 August 1985 on detailed rules and procedures on treatment of dependent persons sentenced for offences related to narcotic or psychotropic substances.		-
Portugal	X	Edict No. 41/88 of 21 November 1988.		-

Table 3 *(continued)*

Country	Yes	Regulation or Ministerial Orders	No	Other documents
Russian Federation			X	-
Spain			X	-
Sri Lanka			X	-
Thailand			X	-
United Arab Emirates			X	Recommendation of Central Mental Health Committee
United Kingdom			X	-
United States of America			X	-
Zimbabwe			X	Acts and regulations on medical and associated health professions

[1] See Annex 2 for legislation on compulsory civil commitment; treatment associated with criminal justice system; compulsory reporting, central registries, laboratory testing and community surveillance.

[2] As reported by personal communications, in survey.

Yes = Specific legislation exists. No = No specific legislation exists.

In Poland, the Ordinance of 3 August 1985 of the Minister of Health and Social Welfare, on drug dependence, reportedly (J. Morawski, personal communication, 1994) requires the primary health care services to participate in drug-abuse prevention activities. After first contact with the health-care system and initial treatment, the patient is referred to specialized centres. For alcohol dependence, primary health-care centres are organized at places of work, or at universities, and are required to participate in the treatment and rehabilitation of alcohol-dependent persons, (J. Morawski, personal communication, 1994).

In Portugal, under Edict No. 41/88 of 21 November 1988, regional alcohol centres must develop their activities in conjunction with psychiatric hospitals, mental

health centres, regional health administrations, associated health centres, general practitioners, institutes, and other institutions and groups responsible for the well-being and health of the community.

Planning for the delivery of pharmaceuticals which are essential for the healthy development of populations is now a well established programmes in primary health care strategy. In Zimbabwe, although there are no special regulations on the development of treatment or rehabilitation services at primary health care level, it is reported (A. Chidarikire, personal communication, 1994) that the list of essential drugs of the Ministry of Health and Child Welfare includes those drugs which a primary health centre may supply. Prescribing guidelines on these drugs are also available. In general, patients are referred from rural health centres or urban clinics to district hospitals then to provincial or general hospitals and finally to central hospitals or mental hospitals.

In Egypt, it is reported (Alkott, personal communication, 1994) that there are no specific regulatory provisions for primary health care practitioners; however, in general, only physicians are authorized to prescribe drugs for medical purposes. Some drugs which are considered to be of an addictive nature are listed in the schedules to Law No.122 of 1989, amending certain provisions of Decree Law No.182 of 1960 concerning the control of narcotic drugs and regulation of their utilization and trade in them, and the prescribing of such drugs is governed by certain regulations. No definite role is played by traditional healers, and no referral system had been established at that time (1994) for mental hospitals and other health facilities or the community.

An example of subsidiary legislation on treatment centres is Notification No. 96, dated 27 July 1988, of the Ministry of Public Health of Thailand on criteria for applications to set up clinics under the Harmful Habit-forming Drugs Act, 1979. Under Section 3, three different categories of clinics may be established, as follows:

1. Clinics which treat narcotic addicts as outpatients or inpatients at the preparatory stage, withdrawal stage, rehabilitation stage, and follow-up stage.

2. Clinics which treat narcotic addicts as outpatients or inpatients at the preparatory and withdrawal stages.

3. Clinics which treat narcotic addicts as outpatients and inpatients at the rehabilitation and follow-up stages.

Detailed provisions are laid down specifying the requirements to be satisfied by clinics in categories 2 and 3. Section 6 specifies the qualifications to be possessed by persons applying to set up clinics in category 3. Other sections deal with the procedures to be followed by the Clinics Inspection Committee, established by the

Narcotic Control Commission under the Act. A model of the form to be used for an application to establish a clinic is given in an annex to the Notification.

In France, Decree No. 92-590 of 29 June 1992 (and the subsequent explanatory Circular No.56 D.G.S./2.D of 6 October 1992) concerns specialized centres for the care of drug-dependent persons. (See Annex 2.3 for a summary of the provisions of Decree No. 92-590). Decree No.92-590 was made pursuant to Law No. 70-1320 of 31 December 1970 (on health measures for the control of drug dependence and the suppression of traffic in, and illicit use of, poisons) and requires care centres to provide, as a minimum: medical and psychological care for drug-dependent persons; as well as social and educational care, including assistance with social integration or reintegration. The centres must also carry out at least one of the following: (i) reception, guidance and provision of information to drug-dependent persons and their families; (ii) withdrawal, and support during withdrawal, when it is carried out in a hospital; and (iii) support for the family environment. The Decree also covers the working procedures and management of the centres. Other treatment-related regulatory instruments in France include the Order of 18 August 1993 on family reception networks for drug-dependent persons run by officially recognized specialized centres for the care of drug-dependent persons. Moreover, the Decree of 26 August 1992, of the Minister of Health and Humanitarian Action in pursuance of Decree No. 92-590 lays down the composition of the application file required in respect of the establishment and extension of a specialized centre for the care of drug-dependent persons.

9.14 Definition of terms

As was observed in the previous WHO survey (Porter, Arif & Curran, 1986), the issue of definitions transcends many aspects of surveys of national legislation. We are primarily concerned with what the legislation actually states in legislative language with regard to definitions.

WHO has published: (*a*) *International statistical classification of diseases and related health problems (ICD-10)*, tenth revision (World Health Organization, 1992a); (*b*) *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines* (World Health Organization, 1992b); and (*c*) *The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research* (World Health Organization, 1993f). These three publications should be consulted as the international standards for currently accepted nomenclature in the field of drug and alcohol dependence. WHO also published in 1994 the *Lexicon of alcohol and drug terms* (World Health Organization, 1994b) as a companion volume to the *Lexicon of psychiatric and mental health terms*; (World Health Organization, 1994c).

Both the 1986 WHO survey (Porter, Arif & Curran, 1986) and the 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987) contain a discussion of statutory

definitions, including a review of technical guidelines on the definition, diagnosis, and behavioural aspects of "drug dependence" and "alcohol dependence", and the terms "treatment" and "rehabilitation".

We found that many of the definitions used in the legislation were incomplete or out of date. This is not surprising, because legislation cannot be revised every year or so to keep up with scientific developments. Nevertheless, when new laws are written, legislatures should ensure that the terms used are in conformity with modern international standards. The WHO guidelines (Curran, Arif & Jayasuriya, 1987) contain a detailed analysis of the following aspects of statutory definitions:

1. Types of definitions:
   - abbreviating definitions;
   - definitions of services or benefits;
   - technical definitions.
2. Definition of "drug dependence":
   - technical guidelines on diagnosis;
   - linkage to the national drug control programme;
   - behavioural aspects.
3. Definition of "alcohol dependence":
   - technical guidelines on diagnosis;
   - behavioural aspects.
4. Combined definition of drug and alcohol dependence.
5. Definitions of "treatment" and "rehabilitation."

Legislation on the treatment of drug- or alcohol-dependent persons should contain specific definitions of essential terms (e.g. drug dependence, alcohol dependence, treatment, and rehabilitation) that are technically and scientifically acceptable and in line with the latest internationally developed scientific nomenclature, and are correct and up to date for clinical purposes. Such legislation should also specify the procedures used in treatment programmes.

The purpose of a definition of drug dependence is to provide guidance to treatment personnel and the courts in dealing with persons alleged to be drug dependent. Because personal liberty is at stake, it is particularly important for purposes of civil commitment for treatment and in procedures for treatment associated with the criminal justice system. Definitions are important throughout all aspects of the national legislative provisions. The main focus of our interest is on definitions in legislative texts concerning the following terms: drug (or alcohol) dependence (or comparable term); treatment; rehabilitation (or comparable term); and harmful use. Properly drafted legislation will contain a section giving the precise definitions of the most important terms as they appear in the text of the legislation reviewed.

Specific statutory definitions of "drug dependence" or "alcohol dependence" (or an equivalent term) were found in the legislation of the following countries :

Bangladesh, Bolivia, China (Hong Kong), Colombia, Costa Rica, Czech Republic, India, Japan, Kenya, Malaysia, Myanmar, Philippines, Poland, Seychelles, Thailand, Tonga, United States of America (Connecticut, Florida) and Venezuela.

9.14.1 *Definition of "drug dependence"*

In the current survey of legislation on compulsory commitment and treatment in the criminal justice system, fewer than half of the national laws with commitment provisions were found to contain a definition of the key concept of drug dependence.

Of the 25 codes (summarized or noted in Annex 2 and containing a definition of drug dependence), 16 were enacted within the last 10 years (1985 or after). Nine codes, namely those of Bangladesh, Czech Republic, Myanmar, New Zealand, Thailand, Tonga, Venezuela, United States of America (Connecticut, Florida) were found to have been enacted since 1988. Of these nine codes, two (New Zealand, Tonga) contain mental health provisions specifically mentioning drug and alcohol dependence.

In the 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987), it was suggested that terms such as "physical dependence" and "psychological dependence" should be abandoned as representing "old ways of thinking" and that drug dependence should be seen as a "sociopsychobiological syndrome". The "syndrome model" was considered to provide a means of taking into account the interaction of the drug, the person, and the environment that produces dependence. This approach is consistent with the recommended definition of "drug dependence" given in the twenty-eighth report of the WHO Expert Committee on Drug Dependence (World Health Organization, 1993c).

It was also noted in the WHO guidelines (Curran, Arif & Jayasuriya, 1987) that most of the national legislation (reviewed in the 1986 WHO survey) then used either the term "drug addict" or "drug dependant". These are often considered more or less identical from a legislative point of view, the essential characteristics usually involving psychic and/or physical dependence caused by periodic or continuous use of an illicit drug or drugs. Moreover, in order to bring out the fact that the seriousness of the dependence justifies compulsory commitment, many countries require a finding that the person has an overpowering urge or desire for the drug.

The WHO guidelines (Curran, Arif & Jayasuriya, 1987) recommended that, in the light of the syndrome model of dependence, such definitions should be replaced by one that allows for the examination of a combination of biological, psychological, and social factors, but does not require evidence of an uncontrollable urge or desire.

The *ICD-10 Classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines* (World Health Organization, 1992b) includes a

chapter entitled Mental and behavioural disorders due to psychoactive substance use, which provides a clinical description of the dependence syndrome and guidelines for diagnosing this disorder.

At its twenty-eighth meeting in 1993, the WHO Expert Committee on Drug Dependence (World Health Organization, 1993c) concluded that it would be less confusing to follow the ICD-10 diagnostic guidelines in not making a distinction between physical and psychic dependence. The Committee also recommended the use of a definition of drug dependence compatible with that used in the report on its sixteenth meeting (World Health Organization, 1969), and reaffirmed at its twentieth meeting (World Health Organization, 1974). The definition of drug dependence recommended by the WHO Expert Committee on Drug Dependence at its twenty-eighth meeting (World Health Organization, 1993c) is as follows:

> Drug dependence
>
> A cluster of physiological, behavioural and cognitive phenomena of variable intensity, in which the use of a psychoactive drug (or drugs) takes on a high priority. The necessary descriptive characteristics are preoccupation with a desire to obtain and take the drug and persistent drug-seeking behaviour. Determinants and the problematic consequences of drug dependence may be biological, psychological or social, and usually interact.

The WHO Expert Committee on Drug Dependence, also at its twenty-eighth meeting (World Health Organization, 1993c), concluded that the term "drug abuse" was ambiguous and should be replaced by "harmful use". It noted that the term "abuse" is used in the international conventions.

The definition of harmful use recommended by the WHO Expert Committee at its twenty-eighth meeting is as follows:

> A pattern of psychoactive drug use that causes damage to health, either mental or physical.

The Committee (World Health Organization, 1993c) also emphasized that the harmful use of drugs by an individual often has adverse effects on the drug-user's family, the community and society in general.

Some examples of definitions of drug dependence, or drug dependence combined with the use of other substances (or equivalent terms) found in the legislation on *compulsory civil commitment and treatment associated with the criminal justice system* are given below in Table 4.

Table 4

Definitions of drug dependence [a,b]

Country or territory	Definition
Bangladesh [a]	(Narcotics-addict is) "a person physically or mentally dependent on narcotics or a person who habitually takes narcotics".
Bolivia [a,b]	(Chemical dependence or drug dependence is) "the psychic and/or physical state resulting from the interaction between a human being and a natural or synthetic drug, the characteristics of which are alterations in behaviour and other reactions caused by the need and impulse to ingest the natural or synthetic drug, periodically or constantly, with the object of again experiencing its effects and sometimes to avoid the malaise produced by withdrawal of the drug".
Canada (Prince Edward Island) [a]	(Drug) means "a substance other than alcohol that is capable of inducing states of euphoria, hallucinations or intoxication". (Drug abuse) means "the abuse of or addiction to a drug". (Drug-abuser) means a "person who abuses or is addicted to a drug".
China (Hong Kong [a])	(Addict) means "a person who, by reason of his addiction to drugs or to intoxicants, is dangerous either to himself or to others or is incapable of managing himself or his affairs or of ordinary proper conduct or is in serious danger of physical or mental disorder".

Table 4*(continued)*

Country or territory	Definition
Colombia [a,b]	(Addiction or drug addiction means) "dependence on a drug with the appearance of physical symptoms when the drug is removed". (Abuse) means "use by a person of a drug which is self-prescribed and taken for non-medical purposes". (Psychological dependence) means "repeated need to consume a drug, regardless of the consequences".
Costa Rica [a,b]	(Drug-dependant means) "anyone presenting a psychological or, sometimes, physical state caused by the interaction of a living organism and a medicament. Drug dependence is characterized by changes in behaviour and by other reactions which always include an irresistible impulse to consume a medicament on a continuous or periodic basis, in order to experience its psychological effects and, sometimes, to avoid the discomfort caused by privation. Dependence may or may not be accompanied by tolerance. A single person may be dependent on one or more medicaments".
Czech Republic [a]	(An individual suffering from dependence derived from alcohol or other habit-forming drugs means in this Law[c]) "a person who is unable to desist permanently from the immoderate or otherwise detrimental taking of alcoholic drinks or of other habit-forming drugs, harming thereby his health or causing serious disruption of social relations".

Table 4 *(continued)*

Country or territory	Definition
India [a,b]	(Addict means) "a person addicted to any narcotic drug or psychotropic substance".
Indonesia [b]	(Narcotic addict) is "someone who utilizes narcotics and is in a state of dependence on narcotics, physically as well as mentally, resulting from the use or abuse of narcotics".
Japan [a]	(Narcotic addict) means "a person who is in a state of narcotic addiction". (Narcotic addiction) means "chronic intoxication with narcotic drugs, cannabis, or opium".
Kenya [a]	(Person suffering from a mental disorder) means "a person who has been found to be so suffering under this Act and includes a person diagnosed as a psychopathic person with mental illness and person suffering from mental impairment due to alcohol or substance abuse" . (Substance abuse) means "the maladaptive pattern of use as indicated by either recurrent or continued use of any psychoactive substances (such as alcohol, amphetamines, cannabis sativa, cocaine, hallucinogens, inhalants, opioids, sedatives, hypnotics, or anxiolytics) where such use causes or exacerbates persistent or recurrent social, occupational, psychological or physical problems".

Table 4 *(continued)*

Country or territory	Definition
Malaysia [a]	(Drug-dependant) means "a person who through the use of any dangerous drug undergoes a psychic and sometimes physical state which is characterized by behavioural and other responses including the compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effect and to avoid the discomfort of its absence".
Myanmar [a]	(Drug-user means) "a person who uses a narcotic drug or psychotropic substance without permission in accordance with the law".
Philippines [b]	(Drug dependence means) "a state of psychic or physical dependence, or both, on a dangerous drug, arising in a person following administration or use of that drug on a periodic or continuous basis".
Poland [a,b]	(Drug-dependant person means) "a person who, as a result of using narcotic or psychotropic substances for medical reasons or through abuse of such substances, becomes dependent on them". (Drug addiction) means "constant or periodic use for non-medical purposes of narcotic or psychotropic substances or their surrogates which may lead or led to dependence" .
Seychelles [b]	(Drug addict means) "a person who through the use of a controlled drug (*a*) has developed a desire or need to continue to take the controlled drug, or (*b*) has developed a psychological or physical dependence upon the effect of the controlled drug".

Table 4 *(continued)*

Country or territory	Definition
Singapore [a]	(Drug addict) means "a person who through use of any controlled drug: (*a*) has developed a desire or need to continue to take such controlled drug; or (*b*) has developed a psychological or physical dependence upon the effect of such controlled drug".
Thailand [a]	(Addiction to a narcotic) means "the using of a narcotic regularly and continuously and getting into a condition of dependence on that narcotic, where it is possible to discover such a condition according to scientific principles". (Narcotic) means a "narcotic under the law governing narcotics and a narcotic under the law governing the prevention and suppression of narcotics"
Tonga [a,b]	(Alcoholic) or (Drug Addict) means "a person suffering from a disorder or disability of the mind caused by his being so given over to or dependent on the use of alcohol or drugs that he is unable to control himself or is incapable of managing his affairs or endangers himself or others".
Venezuela [b]	(Drug-dependant) means "an intense consumer characterized by the consumption of a minimum daily dose, usually motivated by the need to alleviate tension. This is regular consumption rising to consumption levels that may be defined as dependence in such a way that it is transformed into an activity of daily life, even when the individual remains integrated within the community. The compulsive consumer is characterized by high levels of frequent and intense consumption, with physiological or psychological dependence such that his individual and social functioning is reduced to a minimum".

Table 4 *(continued)*

Country or territory	Definition
United States of America (Connecticut) [a]	(Drug-dependant person) means "a person who has a psychoactive substance dependence on drugs as that condition is defined in the most recent edition of the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders'. No person shall be classified as drug dependent who is dependent (*a*) upon a morphine-type substance as an incident to current medical treatment of a demonstrable physical disorder other than drug dependence or (*b*) upon amphetamine-type, ataractic, barbiturate-type, hallucinogenic or other stimulant and depressant substances as an incident to current medical treatment of a demonstrable physical or psychological disorder, or both, other than drug dependence".
United States of America (Florida) [a]	(Habitual abuser) means "a person who is brought to the attention of law enforcement for being substance impaired, who meets the criteria for involuntary admission in s. 397.675, and who as been taken into custody for such impairment three or more times during the preceding 12 months". (Impaired) or (substance abuse impaired) means "a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behaviour".

Table *4 (continued)*

Country or territory	Definition
United States of America (Massachusetts) [a]	(Drug-dependant person) means "a person who is unable to function effectively and whose inability to do so causes, or results from, the use of a drug other than alcohol, tobacco or lawful beverages containing caffeine, and other than from a medically prescribed drug when such drug is medically indicated and the intake is proportional to the medical need".

[a] Found in the legislation on compulsory civil commitment.
[b] Found in the legislation on treatment associated with the criminal justice system.

As can be seen from Table 4, some legislative provisions include the older term "drug addict", but many use the more modern term "drug dependence". The definition of "impaired" or "substance abuse impaired" used in Florida, namely a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behaviour, is consistent with the suggestion in the WHO guidelines (Curran, Arif & Jayasuriya, 1987), previously mentioned, that drug dependence should be seen as a sociopsychobiological syndrome involving the interaction of the drug, the person, and the environment that produces dependence.

9.14.2 *Definition of "alcohol dependence"*

Alcohol dependence is not the subject of any international convention. Accordingly, legislative definitions of alcohol dependence will not refer to it as a controlled substance but will reflect technical guidelines on diagnosis, and behavioural aspects.

The WHO Expert Committee on Drug Dependence, in the report on its twenty-eighth meeting (World Health Organization, 1993c), noted that a dependence-producing drug is one that has the capacity to produce dependence as also defined in its report, and as noted above. The specific characteristics of such dependence will vary with the type of drug involved. The Committee noted that ICD-10 recognizes 10 different types of psychoactive drugs, or drug classes, the self-administration of which may produce mental and behavioural disorders, including dependence. They include

alcohol, as well as cocaine, cannabinoids, opioids, and volatile solvents. The definitions of alcohol dependence found in the legislation on compulsory civil commitment are shown in Table 5.

Table 5

Definitions of alcohol dependence found in the legislation on civil commitment

Country or territory	Definition
Canada (Prince Edward Island)	(Alcoholic) means a "person who suffers from alcoholism". (Alcoholism) means a "condition of psychic or physical dependence on or addiction to alcohol".
United States of America (Connecticut)	(Alcohol-dependent person) means "a person who has a psychoactive substance dependence on alcohol as that condition is defined in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders.*

The legislation in some of the countries covered in the present survey with separate alcohol-related programmes uses the terms "alcoholism" and "alcoholic", but there is a trend to replace these by the modern terms "alcohol dependence" and "alcohol-dependent person". In addition, a few legislative definitions link "alcoholism" to "psychic or physical dependence" on alcohol, e.g. in Canada (Prince Edward Island).

9.14.3 *Definition of harmful use*

The term "harmful use" was not found in any of the legislative definitions in the present survey. However, the Law of 28 March 1989 on the protection against alcoholism and other drugs of the former Czech Republic, (see Table 4), defines an individual suffering from dependence on alcohol or other habit-forming drugs as "a person who is unable to desist permanently from the immoderate or otherwise

detrimental taking of alcoholic drinks or of other habit forming drugs, harming thereby his health or causing serious disruption of social relations".

9.14.4 *Combined definition of drug and alcohol dependence*

The WHO Expert Committee on Drug Dependence, at its twenty-eighth meeting (World Health Organization, 1993c) noted that public health approaches to all psychoactive drugs, including alcohol and tobacco, are increasingly being viewed in a common frame. The Committee observed that, in many countries, treatment services are now located in a single administrative structure, although they retain a specialized and differentiated focus. Patients, are often multiple drug abusers requiring a comprehensive approach. The 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987) suggested that the phrase "drug and alcohol dependence" could be appropriately used to reflect a broad approach covering a comprehensive treatment programme for a full range of dependent states or syndromes.

An example of this approach, which also involves a link with dangerousness, is the definition of "addict" in Section 2 of the Hong Kong Drug Addicts Treatment Rehabilitation Ordinance (1989), namely "a person who, by reason of his addiction to drugs or to intoxicants, is dangerous either to himself or to others or is incapable of managing himself or his affairs or of ordinary proper conduct or is in serious danger of physical or mental disorder". Similarly, the definition in Section 1 of the Tongan Mental Health Act, 1992, defines "alcoholic" or "drug addict" as "a person suffering from a disorder or disability of the mind caused by his being so given over to or dependent on the use of alcohol or drugs that he is unable to control himself or is incapable of managing his affairs or endangers himself or others".

9.14.5 *Definition of methods of treatment*

In a few countries and territories (Bangladesh, Canada (Prince Edward Island), Colombia, Hong Kong, Kenya, Malaysia, Norway, South Africa), the term "treatment" or "treatment centre" (or equivalent term) is specifically defined in the legislative texts.

Some legislation specifies the type of treatment to be administered, setting out a comprehensive range of services. Thus in the Addiction Services Act of 24 April 1981 of the Canadian province of Prince Edward Island, the term "treatment services" is defined as a broad range of emergency, outpatient, and inpatient services provided by a regional community organization and includes: (i) detoxification; (ii) medical examination and diagnostic assessment; (iii) development of a treatment plan for each person participating in a treatment programme; (iv) short-term residential care; (v) rehabilitation measures; (vi) counselling; (vii) follow-up and support; (viii) maintenance of records; and (ix) evaluation of modes of treatment.

In Kenya, the Mental Health Act, 1989 defines "treatment" to include medical treatment, nursing and care and training under medical supervision, and in Colombia, under Law No. 30 of 31 January 1986 adopting the National Narcotic Drugs Statute and enacting other provisions, "treatment" means "the different methods of therapeutic intervention designed to counteract the effects produced by the drug".

Treatment facilities are also defined in some of the legislative texts. In Bangladesh, pursuant to the Narcotic Drugs and Psychotropic Substances Control, Act, 1990, a "narcotics addiction treatment centre" means "a narcotics addiction treatment centre established or so declared under this Act". In Canada (Prince Edward Island), a "treatment centre" or "treatment facility" means "a place in which treatment services are provided and includes a centre or facility operated by, or an agency approved by, the Minister of Health and Social Services".

9.14.6 *Definition of rehabilitation*

The international conventions require Parties to take all practical measures, not only in relation to treatment, but also to after-care, rehabilitation and the social reintegration of the person involved. The 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances provides that Parties may take such measures, either as an alternative, or in addition, to conviction or punishment.

Our survey revealed only a few legislative definitions of rehabilitation services or facilities. In Colombia, Law No. 30 of 31 January 1986 adopting the National Narcotic Drugs Statute and enacting other provisions, "rehabilitation" is defined as "activity leading to the useful reincorporation of a drug-dependent person in society". In Malaysia, "rehabilitation officer" means an officer appointed under the provisions of the Act 283, Drug Dependents (Treatment and Rehabilitation) Act 1983, "as may from time to time be required for the purposes of this Act"; and "rehabilitation centre" means an institution established under paragraph (a) of Section 10 of this Act, which provides that the Minister charged with the responsibility for internal security may, by notification in the official Gazette, establish centres for the residence, treatment and rehabilitation of drug dependents ordered or admitted to reside under the Act.

In order to maintain flexibility in the implementation of policy and the achievement of legislative goals, implementing regulations, circulars, or ministerial orders are most frequently used to cover the day-to-day operational aspects of treatment or rehabilitation facilities. Typically, the legislation provides that authority is delegated to the person in charge of the facility for the provision of services. In turn, the implementing regulations frequently define the terms necessary to guide the administration of the facility. For instance, in the Philippines, the Dangerous Drugs Board has issued Board Regulation No. 5 (Series of 1991, Amended Consolidated Regulations Governing Treatment and Rehabilitation Facilities for Drug Dependents), which define "Rehabilitation", as follows:

> Rehabilitation is a dynamic process directed towards the physical, emotional/psychological, vocational, social and spiritual change to prepare a person for the fullest life compatible with his capabilities and potentials and render him able to become a law abiding and productive member of the community without abusing drugs.

Similarly, in Mexico, Technical Standards under the General Health Law of 1984 contain provisions for the detailed implementation of that Law. Thus Technical Standard No. 197 defines psychosocial rehabilitation as the modification of the consumption habits of persons with drug or alcohol problems and helping them to improve their quality of life, not only personally, but also in the family, at work, and socially.

9.14.7 *Country-level use of legislative definitions*

We asked key informants in the current survey to inform us whether the legislation and regulations contain a specific definition of certain terms, and if so where they could be found. In addition, we asked respondents whether they considered these legislative definitions to be scientifically and clinically correct and up to date, and if they were used for clinical purposes. The terms in question are drug dependence; drug abuse; alcohol dependence; alcohol abuse; harmful use; treatment; and rehabilitation (or comparable term). Many respondents indicated that the definitions used in their countries were, for example, "the ones provided by WHO", or that definitions contained in ICD-9 or ICD-10 are used in legal actions as an "industry standard". One respondent indicated that the definitions were not included in legislative codes, but that the courts used the usual linguistic meaning of all these terms in the administration of the law. Instead of "drug dependence", the terms addict, or addiction are often used, according to the respondents, a fact which can be confirmed by reference to Table 4.

As noted in the 1987 guidelines (Curran, Arif & Jayasuriya, 1987), "linkage" is found in the definitions adopted in many countries in the requirement that the drug of dependence be one included in the general definition of "narcotic drugs" or "controlled substance" found often in the same law as that governing the treatment programme. This practice is modelled on that used in the international conventions, all three of which contain references to national treatment and rehabilitation programmes. The advantage of including a linkage in the legislation on treatment and rehabilitation is that it establishes a direct relationship with the law-enforcement aspects of the total national drug-control effort. Thus the definitions illustrated in Table 4 included earlier in this chapter include the terms "controlled drug" (e.g. Seychelles), or "dangerous drug" (e.g. Malaysia), which is consistent with the international conventions. However, as suggested in the 1987 guidelines (Curran, Arif & Jayasuriya, 1987), many definitions are expanded to include therapeutic but potentially dependence-producing substances that are lawfully obtained. This provides an opportunity for courts and

other decision-makers to encourage and order treatment for persons in need due to dependence so that they may receive the services that they need.

Many respondents considered the legislative definitions not to be scientifically and clinically up to date, or not scientifically or clinically correct. Accordingly, they are not used for clinical purposes. The use of the term "drug abuse" was considered by some respondents as pejorative, and not used in practice. However, others indicated that it was not an "up-to-date" term but was still used, often in clinical practice. Nevertheless, the concepts of abuse and of addiction are found in the legislative definitions given in Table 4.

These comments illustrate the practical problems faced by the courts, which are required to apply the legislative definitions in their decisions. In addition, court decisions must be based on medical criteria, which, as noted, often involves the clinical and diagnostic use of terms which are not scientifically or clinically correct, or appropriate. Finally, the comparatively few definitions in the legislation are not in line with modern nomenclature as used in ICD-1O.

10. Voluntary treatment

10.1 General

As pointed out in the previous WHO survey (Porter, Arif & Curran, 1986), both the legal system and the treatment programme should facilitate the attainment of individual objectives. An individual's personal desire to be treated for alcohol and drug dependence is an extremely important indicator of the likelihood of success in treatment. The legal provisions whereby a person is guided into the treatment system should be explicitly designed to maximize the free exercise of choice and discretion. Compulsion can sometimes be a positive element in the entry process, but cannot guarantee the success of the treatment programme. In order to maximize individual motivation for treatment, entry into, and continuation of, treatment for alcohol and drug dependence should be voluntary whenever possible within the context of the legal system, culture and socioeconomic development of the country concerned.

As indicated in the WHO guidelines (Curran, Arif & Jayasuriya, 1987), "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 first group comprises those who are fully aware of the need for treatment and who seek it without requiring any type of coercion. The second includes a wider spectrum of persons whose reluctance to seek treatment is overcome, e.g. by pressure from the family or employer, the growing cost of the drug habit, and the fear of criminal prosecution if no effort is made to seek treatment.

As pointed out by the WHO guidelines (Curran, Arif & Jayasuriya, 1987), when national treatment programmes include voluntary care, the provisions commonly authorize adults to apply directly to treatment centres for the care they require. The centres however, are under no obligation to accept such patients, as may be the case when compulsory commitment is ordered by the courts.

Several countries also authorize parents and guardians to apply for voluntary admission for minors (usually between the ages of 14 and 16) diagnosed as drug- or alcohol-dependent. A small number of countries allow minors (usually somewhat older) to apply themselves for voluntary care without the permission of their parents or guardian. Another type of voluntary procedure allows a relative or friend of a drug- or alcohol-dependent person to apply voluntarily for that person to be examined and treated, provided that the dependent person (usually an adult) does not refuse such examination and treatment.

If a parent or guardian or family member is applying for commitment of a minor, it is recognized that this is not spontaneous, voluntary treatment as can be understood by the public at large. However, if such patients, although not spontaneously seeking care, are aware of their need for treatment and able to

understand its nature and to cooperate with those providing it, they can be admitted legally as voluntary patients.

Legislation should provide for a comprehensive range of services necessary to meet the needs of persons seeking voluntary admission for treatment and rehabilitation. Voluntary treatment in the community, or in close proximity to the patient's home or other primary care facilities, is to be preferred. For example, the treatment services which may be provided in Canada (Prince Edward Island) under the Addiction Services Act, dated 24 April 1981, include a broad range of emergency, outpatient, and inpatient services provided by a regional community organization. In Singapore, since 1996, a government programme provides "Amnesty for drug experimenters and first time drug users not already an offender". Drug users are permitted to enter treatment, voluntarily, at selected hospitals, to undergo detoxification at their own cost, before they are arrested and prosecuted (Singapore, 1998).

In the Hong Kong Special Administrative Region, in China, a drug-dependent person may choose the type of voluntary service which best meets his circumstances. Hong Kong has developed four distinct modalities as follows:

a. The residential programmes with comprehensive rehabilitation and aftercare services operated by SARDA for male and female narcotic dependents.
b. Outpatient methadone maintenance and detoxification clinics operated by the Government Department of Health with its counselling service provided by SARDA thereby establishing an efficient network of mutual referral and convenient transfer of patients according to their requests.
c. A number of smaller therapeutic communities operated by religious groups emphasizing spiritual rehabilitation.
d. Substance abuse clinics and drop-in counselling centres operated by both the Government Hospital authorities and voluntary agencies primarily for psychotropic and polydrug users.

In Hong Kong, under the Drug Addicts Treatment Centres Ordinance, Chapter 326 of the revised Edition 1989 (Ordinance No. 34 of 1960) once a person (or, if a minor, the parents or guardian) files an application for voluntary admission to a treatment centre, the person may be admitted. However, the application must contain an acknowledgement by the person that the person named in it may be detained against his will in the centre for a period not exceeding six months and may be forcibly retaken by the police if he absents himself from it without permission.

Legislation requiring a contract between the patient and the provider of treatment services was identified in several jurisdictions (e.g. Denmark, Hong Kong, Norway, Sweden). Some ministerial regulations or other administrative provisions in some jurisdictions (e.g. Bahrain) specify the terms of such "treatment contracts". These can have a positive effect and may tend to reduce patient dependence and consequent institutionalization, promote self-autonomy, create a partnership between patients and

therapeutic communities and, in the transitional period, carry out resocialization activities aimed at eventual reintegration into the community.

10.2 Treatment contracts

Treatment contracts between patient and institution vary widely in their purpose and scope. In Cyprus, it is reported (V. Pyrgos, personal communication, 1994) that drug-dependence treatment is provided in one 10-bed inpatient clinic in the Nicosia General Hospital. The aim of the programme is to ensure that persons, after treatment, will be drug-free. The programme is offered to people who volunteer for treatment and sign a contract with the clinic. Contracts between patient and institution on voluntary entry may involve subsequent compulsory measures if the patient does not fulfil the treatment requirements. For example, in Denmark under Law No. 349 of 14 May 1992, a drug-dependent person who has entered treatment voluntarily may later be subject to compulsory detention when: (*a*) there is reason to believe that the treatment agreed upon might be interrupted; and (*b*) when it is considered irresponsible not to detain the person because the prospects of a decisive improvement in his general condition will be severely impaired, and the person represents an imminent and considerable cause of possible harm to himself or others. Treatment contracts may require the patient's agreement to abide by the rules of the institution e.g. patients receiving treatment as day patients must report to the institution's social workers; and attend group therapy sessions at certain times prior to receiving prescribed medication. (See Ministry of Health Ministerial Decision No. 28 in the United Arab Emirates, for year 1987 dated 25 January 1987 which establishes the internal procedures for drug addiction units, including addiction treatment aims, voluntary admission, methods of discharge and visiting.)

In Peru, Ministerial Resolution No. 172-95-SA/DM of 27 February 1995 adopts the supplementary rules intended to facilitate the implementation of Supreme Decree No. 06-94-SA of 13 December 1994 on care centres for drug-dependent persons. Section 8 of the Resolution requires applicants (e.g. patient, patient's family, tutors, guardians) to sign a therapeutic contract in which the following must be specified: *(a)* the responsibility upon admission, of the person signing the application; *(b)* the causes likely to constitute grounds for exclusion; *(c)* the system applicable to outside contacts; *(d)* the financial conditions of the stay; *(e)* the duties of the patient and the centre; *(f)* the undertaking of the patient's assurance to participate in the patient's rehabilitation; and *(g)* a summary of the programme of rehabilitation that the patient is to undergo. (IDHL, 1998, 49[3].

11. Restrictive or compulsory procedures

11.1 General

Compulsory confinement for treatment has been one legal response to deviant behaviour, including mental illness, and drug and alcohol dependence. When the purpose of such deprivation of liberty is treatment, however, such confinement necessarily involves a conflict with the legally protected values of individual liberty and freedom of decision (Porter, Arif & Curran, 1986).

Compulsory civil commitment of persons dependent on drugs or alcohol will continue to be considered in some countries as an appropriate method, under certain narrowly defined circumstances. The WHO guidelines (Curran, Arif & Jayasuriya, 1987) for assessing and revising national legislation on the treatment of drug- and alcohol-dependent persons recommends that a comprehensive treatment programme for drug and alcohol dependence should include provision for restrictive or compulsory procedures (i.e. all procedures not initiated voluntarily).

The WHO guidelines (Curran, Arif & Jayasuriya, 1987) also suggested that compulsory treatment should include both outpatient and residential treatment; and that a comprehensive programme should include a variety of less restrictive compulsory procedures including general community treatment; outpatient day centres; halfway houses; and group homes. The WHO guidelines indicated that such a range of options will be broader than that found in most mental health codes or in the most recent specialized legislation on the treatment of drug- or alcohol-dependent persons. It was emphasized that the important feature is that each of these options is compulsory, since the nature of substance dependence demands this approach. Nevertheless each is also community-based to some extent and does not require long-term residence in a closed institution.

The criteria for the compulsory civil commitment of drug- or alcohol-dependent persons should be clearly stated in the legislation. Some provisions of this type can be found in the legislation summarized in Annex 2.

11.2 Compulsory civil commitment legislation

Compulsory civil commitment means the involuntary admission by judicial or administrative order, usually to an inpatient facility, for the treatment of drug or alcohol dependence, on the grounds stated in the civil law. Compulsory civil commitment provisions were found in the following seven categories of legislation:

1. General mental health legislation.
2. Mental health legislation specifically mentioning drug or alcohol dependence.
3. Social services legislation specifically mentioning drug or alcohol dependence.
4. Special civil commitment legislation on drug dependence.
5. Special civil commitment legislation on alcohol dependence.
6. Combined approaches applying to both drug and alcohol dependence.
7. Special legislation on volatile solvent inhalants.

Social services laws providing for the involuntary admission of drug- or alcohol- dependent persons were identified in four jurisdictions: Finland, Norway, Sweden and Ukraine. In Norway the Act on Social Services of 13 December 1991 providing for involuntary civil commitment, came into force on 1 January 1993. Moreover, legislation providing for involuntary detention of pregnant drug users came into force on 1 January 1996. As noted by The Norwegian Directorate for the Prevention of Alcohol and Drug Problems and The National Institute for Alcohol and Drug Research report (Norway, 1998), while voluntary entry to treatment is the main principle for drug treatment, the changes in law permit for more use of compulsion. The legislative intent of the 1996 law is to meet concerns for the unborn child; and in the 1993 law relates to the drug user. In both laws, the objective of compulsion is to motivate the drug user to consent to voluntary treatment. The drug user can be detained permissibly for up to three months; more alcohol misusers than drug users have been detained involuntarily under these provisions, it is reported (Norway, 1998). In Sweden, under the Social Services Act (SFS 1980:620) of 19 June 1980 (as amended), the care and treatment of drug-dependent persons involves the coordination of the social and medical services, a system of outreach activities, detoxification, outpatient care, institutional care, and discharge services. Municipal services are mainly responsible for the care and treatment of drug-dependent persons. Under the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act/LVM/ (SFS 1988:875), cases that may require compulsory care are investigated by the Municipal Social Welfare Committee, and the County Administrative Court then decides whether such care is necessary, and issues compulsory care orders.

In France, the adequacy of substance-abuse services at the municipal level has been the subject of Government attention. National regulations providing for municipal, hospital at the community (municipal) level exist in France. The Ministry of Health and Social Affairs has issued circular DGS-DH No.15 of 7 March 1994 with the complementary objectives of reserving certain hospital beds for detoxification, and the development of municipal networks consisting of general practitioners, hospitals, specialized treatment centres, and social services.

Co-morbidity, or the presence of two or more illness in the same person simultaneously or sequentially, creates difficult issues for decision-makers in this

field.[20] The research in this field is equivocal, and there is significant variability across studies. Clinical populations generally demonstrate higher rates of co-morbidity than samples drawn from the community. In addition, co-morbidity affects both the course of illness and the response to treatment. Although systematic studies are not available from developing countries, clinical impressions point to a low prevalence even in psychiatric settings. It is suggested that legislation should provide for innovative approaches, especially in non-institutional settings, to the treatment of drug dependence.

A number of countries have combined legislation (i.e. legislation covering persons who are either drug- or alcohol-dependent, or poly-dependent. In four of these (Bangladesh, Iraq, New Zealand, South Africa), the legislation is primarily concerned with drug dependence but alcohol is brought within its scope by defining alcohol as a drug, or alcohol dependence as a type of drug dependence. The remaining jurisdictions with combined legislation contain comprehensive substance-abuse provisions covering both alcohol dependence and drug dependence. One (Sweden) has legislation also covering volatile solvent inhalants. The relatively small number of combined legislative approaches applying to both drug and alcohol dependence is probably misleading. There are countries where combined approaches are widely accepted despite legislative provisions dealing separately with drugs and alcohol. For example, in Poland, it is reported (anonymous, personal communication, 1994) by the head of a detoxification unit for drug-dependent patients that alcohol and drug treatment are separate according to the law and in line with treatment traditions, but that there is nevertheless some overlap between the alcohol- and drug-dependent populations. It is also reported (anonymous, personal communication, 1994) by the head of an alcohol unit at a psychiatric hospital that, although alcohol and drug treatment are formally separate, the law does not prohibit the application of a combined approach. Accordingly, adults dependent both on legal drugs and alcohol are sometimes admitted to the hospital. However, the majority of drug-dependent and alcohol-dependent persons are so different that their treatment within a single programme would not be successful. Moreover, in the United Kingdom, it is reported (D. Cameron, personal communication, 1994) that specialist units in some areas of the country operate combined programmes, e.g. there are common facilities for drug and alcohol misuse at Leeds, Newcastle-upon-Tyne, and Nottingham, whereas others operate separate services, e.g. at Edinburgh, Leicester, and Liverpool. Such local differences seem to have arisen as a result of provider preference, history, and because the 1983 Government central funding initiatives related specifically to drugs and excluded alcohol (D. Cameron, personal communication, 1994). In India, in the opinion of one respondent (M. Suresh Kumar, personal communication, 1994), "there is no need to

[20] Participants at the Harvard Advisory Group meeting addressed co-morbidity treatment issues, and what follows states the main elements of the paper presented at the meeting by Dr R. Srinivasa Murthy (R.S. Murthy, unpublished observations, 1994).

have separate drug and alcohol programmes, as there are many common characteristics and it may be cost effective to have a combined approach".

Two countries (Mexico, Sweden) provide for compulsory civil commitment specifically for users of volatile solvent inhalants. The Swedish Act/LVM of 1988 on the care of alcoholics, drug abusers, and abusers of volatile solvents (special provisions) amended a 1982 law by extending from two to six months the permitted duration of treatment, and adding persistent abuse of volatile solvents as a ground for compulsory treatment.

Table 6 shows the countries and territories having specific legislation on the treatment of drug- and alcohol-dependent persons, together with the types of legislation existing in these countries.

Table 6

Specific legislation on involuntary entry for the treatment of drug- and alcohol-dependent persons

Country or territory	Mental health	Social services	Drug dependence	Alcohol dependence	Combined drug and alcohol dependence	Volatile solvent inhalants	Specific youth provisions
Australia (New South Wales)	X						
Australia (Queensland)				X			
Austria			X				X
Bahrain	X						
Bangladesh					X		
Bolivia			X				X
Canada (British Columbia)			X				
Canada (Prince Edward Island)					X		
Canada (Nova Scotia)			X				
China (Hong Kong)			X				X
China (Macao)			X[a]				
Colombia			X				

Table 6 *(continued)*

Country or territory	Mental health	Social services	Drug dependence	Alcohol dependence	Combined drug and alcohol dependence	Volatile solvent inhalants	Specific youth provisions
Czech Republic	X		X		X		
Denmark			X				
Ecuador			X				
Finland		X					X
Germany (Bavaria)	X						
Greece			X				
Hungary				X			X
India	X		X				X
Indonesia			X				X
Iraq					X		
Ireland	X						
Italy			X				X
Kenya	X						
Japan			X				
Kuwait			X				
Malaysia			X				X
Mexico	X					X	X
Myanmar			X				
New Zealand	X				X		
Norway	X	X					X
Peru			X				X
Poland			X	X			X
Portugal			X				

Table 6 *(continued)*

Country or territory	Mental health	Social services	Drug dependence	Alcohol dependence	Combined drug and alcohol dependence	Volatile solvent inhalants	Specific youth provisions
Russian Federation	X		X	X			X
Singapore			X				
Slovakia	X						
South Africa					X		X
Spain (Catalonia)			X				
Sweden		X		X	X	X	X
Switzerland (Geneva)				X			
Thailand			X				
Tonga	X						
Tunisia			X				
Ukraine		X		X			
United Kingdom	X						
United States of America (federal)			X				
United States of America (Connecticut)				X	X		X
United States of America (Florida)					X		X
United States of America (Massachusetts)	X			X			X
Venezuela			X				
Viet Nam			X				
Zimbabwe	X						

[a] Up to 1991.

11.3 Restrictive and compulsory procedures

Provisions for restrictive and compulsory procedures, including compulsory civil commitment, were found in the specific legislation on drug dependence of 27 countries, in the legislation on alcohol dependence of eight countries, and in combined legislative approaches in eight countries. Some countries had both specific and combined legislation.

In the African region, provisions for compulsory treatment exist in several countries (Kenya, South Africa, Zimbabwe). In some jurisdictions, in addition to drug dependence, the grounds for commitment must also include harmful use as a consequence of dependence. In South Africa, under the provisions of the Prevention and Treatment of Drug Dependency Act, 1992, the grounds for commitment are dependence on drugs as a consequence of which the person concerned squanders his means or injures his health or endangers the peace or in any other manner harms to his own welfare or the welfare of his family, or fails to provide for his own support or for that of any dependent whom he is legally liable to maintain. A magistrate may order a person satisfying these criteria to be detained and treated in a treatment centre or registered treatment centre.

In Zimbabwe, the Mental Health Act, 1976, makes no mention of drug or alcohol dependence; but drug and alcohol abusers who do not voluntarily enter treatment can be compelled to do so under Section 44 of the Act (P.S. Madzonga, personal communication, 1994).

In the Region of the Americas, numerous countries (Bolivia, Canada, Colombia, Costa Rica, Ecuador, Peru, United States of America, Venezuela) have made provision for compulsory treatment. Thus, in Bolivia, Law No. 1008 of 19 July 1988 requires drug-dependent persons to be committed to a public or private institution for drug dependence to receive treatment until such time as their rehabilitation has been established with certainty. Rehabilitation is defined in the Bolivian legislation to mean biopsychosocial readjustment, or reintegration into the normal activity of society. Under Supreme Decree No. 22099, stating the Regulations in application of Law No. 1008 of 28 December 1988, institutes for treatment and rehabilitation are under the control and supervision of the Ministry of Social Welfare and Public Health.

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

programme. The social reintegration of drug-dependent persons is the fundamental objective of the care team.

In the European Region, in Sweden (Sweden, 1998a), under the provisions of the Care of Young Persons (Special Provisions) Act/LVU (SFS 1990:52), with amendments up to and including SFS 1997:1097, a care order is 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. Care is deemed to have begun when the young person has been placed away from his own home under an immediate custody or care order. The social welfare committee or the person charged with the care of the young person by the committee must keep the young person under surveillance and make such decisions concerning his personal circumstances as are necessary for the delivery of care. Specially approved homes must be maintained for the care of young persons requiring particularly close surveillance on the grounds referred to in Section 3 of the Act (the use of addictive substances). The Government, or, by authority of the Government, the National Board of Health and Welfare, must determine which homes are to be regarded as homes for special surveillance of this kind. Reference should be made to the text of the Swedish Act for details of the administrative and enforcement procedures.

In Sweden[21], the results of a 1992 survey of homes providing both shelter and treatment revealed that there were 206 such homes treating both alcoholics and multiple substance abusers, 84 dealing with alcoholics only, and 24 dealing primarily with drug dependence. Among adult substance abusers, the prospect of compulsory intervention often has the effect of motivating persons to remain in voluntary care. Coercion may save lives, particularly among highly debilitated alcoholics, and has often been found to be the only way to provide long-term treatment for serious drug addicts and multiple substance abusers. The Swedish model should be useful to both developed and developing countries in seeking programme alternatives and updated legislation in the field.

Provision for compulsory treatment is also found in several countries of the South-East Asia Region. In Bangladesh, under the Narcotic Drugs and Psychotropic Substances Control Act, 1990, the grounds for civil commitment are the "person often remains in a state of "abnormalcy" for being addicted to narcotics and his treatment is urgently necessary to bring him back to normal life".[22] In India, the Mental Health Act, 1987, provides that separate psychiatric hospitals and nursing homes for the care of

[21] Participants at the Harvard Advisory Group meeting addressed compulsory measures for treatment and rehabilitation in Sweden. The following paragraph states the main elements of a paper on compulsory measures for treatment and rehabilitation in Sweden presented at the meeting by Dr Vera Segraeus (V. Segraeus, unpublished observations, 1994).

[22] Unofficial translation by the Department of Narcotics Control (official text in Bangla).

alcohol- and drug-dependent persons may be established. The Narcotic Drugs and Psychotropic Substances Law of Myanmar (enacted in January 1993) provides that the Ministry of Social Welfare, Relief and Resettlement will, in respect of the rehabilitation and after-care of drug-users - render such assistance and protection as may be necessary to persons undergoing medical treatment and to the families dependent on them; provide for such rehabilitation and vocational training as may be necessary, resettlement and after-care to enable persons who have undergone medical treatment to resume their normal lives; and conduct advanced training courses in order to implement systematically and effectively the work of rehabilitation of drug-users.

Surveillance may be compulsory following hospitalization, or provided for under compulsory care order, as in Special Administrative Region, China (Hong Kong) in the Western Pacific Region. Under the Drug Addiction Treatment Centres Ordinance (Revised Edition, 1988), the Commissioner of Correctional Services may order that a person released from an addiction treatment centre be subject to supervision for a period of 12 months from the date of release. While under such supervision, the person must comply with such requirements (e.g. medical examination, residence) as the Commissioner may specify. The Commissioner may at any time vary or cancel a supervision order. A person who fails to comply with the supervision order commits an offence and is liable to a fine of HK$ 5000 and to imprisonment for 12 months. The Commissioner may make a recall order against the person requiring him to return to an addiction-treatment centre, if the Commissioner is satisfied that a person under a supervision order has failed to comply with any requirement of that order.

Table 7 lists countries and territories providing for the compulsory treatment of persons under: (*a*) mental health legislation; (*b*) social services legislation; (*c*) legislation specifically on drug dependence; (*d*) legislation specifically on alcohol dependence; (*e*) legislation on both drug and alcohol dependence; and (*f*) legislation on volatile solvent inhalants. Reference should be made to the summaries of legislative provisions in Annex 2 and to the original texts for more detailed information.

Table 7 Legislation on compulsory treatment

Type of legislation	Countries and territories
Mental health	Australia (New South Wales), Bahrain, Czech Republic, Germany (Bavaria), India, Ireland, Kenya, Mexico, New Zealand, Norway, Russian Federation, Slovakia, Tonga, United Kingdom, United States of America (Massachusetts), Zimbabwe
Social services	Finland, Norway, Sweden, Ukraine
Drug dependence	Austria, Bolivia, Canada (British Columbia, Nova Scotia), Colombia, Czech Republic, Denmark, Ecuador, Greece, China (Hong Kong), India, Indonesia, Italy, Japan, Kuwait, Macao [a], Malaysia, Myanmar, Peru, Poland, Portugal, Russian Federation, Singapore, Spain (Catalonia), Thailand, Tunisia, United States of America (Federal), Venezuela, Viet Nam
Alcohol dependence	Australia (Queensland), Hungary, Poland, Russian Federation, Sweden, Switzerland (Geneva), Ukraine, United States of America (Connecticut, Massachusetts)
Combined drug and Alcohol dependence	Bangladesh, Canada (Prince Edward Island), Czech Republic, Iraq, Ireland, New Zealand, South Africa, Sweden, United States of America (Connecticut, Florida)
Volatile solvent inhalants	Mexico, Sweden

[a] Up to 1991.

Of the compulsory civil commitment laws in the current survey, many provide for the specialized compulsory commitment of young persons (e.g. minors, children, youths, young persons, juveniles, adolescents, persons under a certain age), indicating the attention given by legislators to substance abuse among minors. The following countries and territories have laws of this type: Austria, Bolivia, China (Hong Kong), Ecuador, Hungary, India, Indonesia, Italy, Malaysia, Mexico, Norway, Peru, Poland, the Russian Federation, South Africa, Sweden and the United States of America (Connecticut, Florida, Massachusetts).

Legislation should designate the agency or agencies responsible for the treatment programme (Curran, Arif, Jayasuriya, 1987).

We found several examples of legislation assigning responsibility for the treatment programme clearly to a particular agency. For example, in a United States of America (Connecticut) law (Public Act 93-381 of 1 July 1993, Section 17a - 664, Chapter 319) consolidating public health and addiction services, reference is made to "creating subregional planning and action councils" at the local community level. These councils determine substance abuse problems, identify "gaps" in services, and design needed programmes. In legislation specifically on drug control and treatment in Bangladesh, the establishment of a national Narcotics Control Board and a Department of Narcotics control to implement its provisions, ensures not only appropriate agency designation but also establishes linkages among all the agencies involved.

11.4 Grounds

The grounds for compulsory civil commitment, and the type of legislation containing the relevant provisions, vary widely. As pointed out in the 1986 WHO survey (Porter, Arif & Curran, 1986), in mental health legislation, it is usually specified that, to be involuntarily committed, a person must be a danger to himself or to others, or suffer from drug- or alcohol-induced psychosis or serious mental deterioration. In many countries, "dangerous behaviour" is specified in the mental health legislation as a ground for the commitment of the mentally ill, and drug or alcohol dependence is often specifically mentioned as an associated or contributing factor in such dangerous behaviour or mental illness. For example, in Kenya, under the Mental Health Act, 1989, a person suffering from a mental disorder who is likely to benefit from treatment in a mental hospital may be committed to such a hospital as an involuntary patient for treatment; the term "person suffering from a mental disorder" is defined in the Act, and includes a person suffering from mental impairment due to alcohol or substance abuse. In some countries, mental health legislation specifically mentioning drug or alcohol dependence provides that no person may be permissably confined involuntarily for treatment solely on grounds of dependence on alcohol or drugs (United Kingdom, Mental Health Act 1983), or, by reason only of substance abuse (New Zealand, the Mental Health (Compulsory Assessment and Treatment) Act, 1992). In some countries, persons may be committed under mental health legislation even though drug or alcohol dependence is not specifically mentioned. For example, in the Russian Federation, the Law of 2 July 1992 on psychiatric care and the safeguarding of citizens' rights in the dispensing of such care reportedly (V.E. Pelipas, personal communication, 1994) applies in practice to the commitment of drug- and alcohol-dependent persons if the required grounds exist, i.e. the person suffers from a serious mental disorder, and: (*a*) constitutes an immediate danger to himself or those around him; (*b*) is helpless, i.e. incapable of meeting the basic requirements of day-to-day living on his own; or (*c*) will suffer substantial impairment of his health as a result of the deterioration of his mental state, if he is left without psychiatric care.

As emphasized in the previous WHO survey (Porter, Arif & Curran, 1986), persons in need of short-term emergency commitment include incapacitated drug- or alcohol-dependents. Present legislative trends require the police to assist incapacitated alcohol abusers to enter the treatment system instead of arresting them. Similarly, a drug-dependent person may be incapacitated while under the influence of drugs and in need of medical care, and may also require emergency care as a result of acute withdrawal symptoms and be in need of detoxification.

Admission for emergency care and detoxification is considered as involuntary when it is requested by law-enforcement or medical or social services personnel because the patient, by reason of acute intoxication or other physical or neurological damage, is unable to understand his or her condition; and is in need of treatment.

Treatment for such alcohol or drug emergencies should be for short periods only, and the person should be immediately released from detention on the completion of medical treatment (detoxification).

In addition to such acute medical emergencies, compulsory civil commitment legislation might provide for the disposition of persons who are drug- or alcohol-dependent and, as a result, severely mentally disabled. Many grounds for commitment relate to the severity or degree of impairment; words such as "serious" or "incapable" are frequently used in the legislation. Thus in Norway, under the Mental Health Act of 1961, as amended, the criteria for compulsory civil commitment is that admission to hospital is essential because the patient presents "serious danger to himself or others".

In some jurisdictions (New Zealand, Sweden, Switzerland (Geneva), United States (Connecticut)), incapacitation due to alcohol intoxication plus a need for medical attention are grounds for assistance and transport to a treatment facility pursuant to a "protective custody" order or similar provision. Under the Swedish Act on Detention of Intoxicated Persons (SFS 1976:511) of 10 June 1976, any person found in an indoor or outdoor public place in a state of intoxication caused by alcoholic beverages or other intoxicants, may be detained by a policeman if his condition renders him unable to look after himself or he is otherwise dangerous to himself or to others. If his condition so requires, the person must undergo a medical examination as soon as possible and, if necessary, be hospitalized. In the United States of America (Connecticut) Chapter 319 of the General Statutes, Section 17a - 625 provides that (*a*) any police officer finding a person who appears to be intoxicated in a public place and in need of help may, with such person's consent, assist such person to his home, a treatment facility, or a hospital or other facility; (*b*) any police officer finding a person who appears to be incapacitated by alcohol shall take him into protective custody and have him brought "forthwith" to a treatment facility which provides medical triage. No arrest is made in these circumstances.

In the United States of America (Florida), a person meets the criteria for the various types of involuntary admissions provided for in the Hal S. Marchman Alcohol and Other Drug Services Act of 1993 (including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment), if there is good reason to believe that the person is "substance abuse impaired". This term is defined in the Act as a condition involving the use of alcohol or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behaviour. There must also be good reason to believe that the person who is substance abuse impaired, because of such impairment: (1) has lost the power of self-control with respect to substance use; and either (2)(*a*) has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or another; or (*b*) is in need of substance-abuse services and, by reason of substance-abuse impairment, his judgement has been so impaired that he is incapable of appreciating his need for such services and of making a rational decision in regard thereto. Mere refusal to receive such services, however, does not constitute evidence of lack of judgement with respect to his need for such services.

In some drug or alcohol legislation, the criterion for compulsory admission is solely that a person is dependent on drugs or alcohol (Czech Republic, Japan, Kuwait, Malaysia, Poland, Thailand, Tunisia). Suitability for treatment is often also included among the criteria.

In Poland, the grounds for compulsory treatment, under Law No. 15 of 31 January 1985, are that the person to be civilly committed is a drug-dependent person, i.e. a person who, as a result of using narcotic or psychotropic substances for medical reasons or through the abuse of such substances, becomes dependent on them. Under the Law of 28 March 1989 of the Czech Republic on the Protection Against Alcoholism and Other Drugs, the grounds for commitment are dependence on alcohol or other habit-forming drugs. An individual suffering from dependence on alcohol or other habit- forming drugs is defined as a person who is unable to desist permanently from the immoderate or otherwise detrimental consumption of alcoholic drinks or of other habit- forming drugs, harming his health thereby or causing serious disruption of social relations. Harm to personal health, as well as the disruption of social relations, are important components in establishing that the person meets the criteria for involuntary commitment.

In Finland, legislative provisions for the treatment and rehabilitation of alcoholics and drug addicts are included in the Act on Welfare for Alcoholics and Drug Addicts, and the Social Welfare Act. The provisions governing the rehabilitation allowance granted in support of the rehabilitation of alcoholics and drug addicts are included in the Act on the Rehabilitation Allowance.

It is reported (V.E. Pelipas, personal communication, 1994) that beginning in 1967, compulsory treatment of alcohol dependent persons was introduced by the U.S.S.R. Supreme Council Presidium's Order on Compulsory Treatment and labor re-education of alcohol addicts, followed by other orders for compulsory treatment, including the Decree of 1 March 1974 on the compulsory treatment and occupational rehabilitation of chronic alcoholics (Porter, Arif & Curran, p.186). However, it is further reported that new trends in political development resulted in a change in attitudes to alcohol dependent persons. Accordingly, in the Russian Federation, the Decree of the Supreme Council of the Russian Federation of 21 June 1993 on Implementing the Russian Federation Law on Institutions and Organs Executing Criminal Punishments in the Form of Imprisonment, provides for the closure of medical and labour preventoria. As of 1 June 1994, a number of the Orders of the Presidium of the Supreme Soviet of the former USSR concerning compulsory treatment became invalid. Persons assigned to labour rehabilitation preventoria were released, including those evading voluntary treatment and those continuing to consume alcohol after treatment. 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 has already been mentioned.

Inhalant abuse is a substance abuse problem increasingly mentioned in the national drug strategies such as the 1998-1999 to 2002-2003 Australian strategy (Australia, 1998), with particular reference to young persons; in Western Australia a comprehensive approach to solvent abuse, in regional centres and communities is to be led by the Health Department (Western Australia, 1999).

Grounds for the compulsory treatment of inhalant and volatile solvent users are found in the legislation of several countries. In Sweden (Sweden, 1998b), the Care of Abusers (Special Provisions) Act/LVM/ (SFS 1988:870) with amendments up to and including SFS 1996:1648, applies to persons who, as a result of a continuing misuse of alcohol, drugs or volatile solvents are in need of treatment in order to discontinue misuse, and the need of treatment cannot be satisfied in accordance with the provisions of the Social Services Act or in some other way. The 1989 revisions added abuse of volatile solvents, and extended from two months under prior law to six months the maximum duration of involuntary care. Many changes were made with young persons in mind (Segraeus V, 1994). The grounds require that, as a consequence of his misuse, the person seriously endangers his physical or mental health, runs an obvious risk of destroying his life, or is likely to inflict serious damage on himself or someone with whom he has a close relationship. Agencies which regularly come in contact with misusers through their own activities are required to report to the County Administration (Sweden, 1999a)[23] if they learn that a person can be presumed to be in

[23] *Law and Justice*, published by the Swedish Institute, in 1999, describes national administration in Sweden: "At regional level, the national government is represented by the county administration ... Under the county administration, local authorities have important tasks within, e.g., social welfare." (Sweden, 1999a).

need of treatment under the Act. This reporting requirement does not apply to health and medical services, except that a medical practitioner must report to the County Administration if in the course of his duties he comes in contact with a person who can be presumed to be in need of care under the Act and in his judgement neither he nor the general health and medical services can be instrumental in providing that person with satisfactory treatment or care. Care under the compulsory Mental Care Act (1991:1/28) does not preclude compulsory care under the Care of Abusers (Special Provisions) Act. In Kenya, under the provisions of the Mental Health Act, 1989, emergency admission may be ordered for persons suffering from mental impairment due to alcohol or substance abuse; the latter is defined as the maladaptive pattern of use as indicated by either recurrent or continued use of any psychoactive substances including inhalants.

In Mexico, the General Health Law of 1984 covers the abuse of substances under its mental health provision. Under the Regulations of 7 January 1981, Article 17 requires the Ministry of Health and Welfare to provide medical and social assistance to anyone suffering from the effects of inhaling substances which are psychotropic when inhaled. The appropriate health, educational and rehabilitative measures must be taken in the case of habitual or repeated inhalation of such substances.

The grounds for compulsory civil commitment in a number of countries and territories are shown in Table 8.

Table 8
Grounds for compulsory civil commitment

Country or territory	Grounds
Australia (New South Wales) (Mental Health Act 1990)	Person mentally disordered from alcohol and other drugs
Australia (Queensland) (Liquor Act 1992)	Appears to local Council that a person ordinarily resident in its community area, because of consumption of liquor: (*a*) endangers, or is likely to endanger, the life, safety or well-being of the person's family or another person ordinarily resident in the community area; or (*b*) threatens, or is likely to threaten, the peace and good order of the community area; or (*c*) endangers or is likely to endanger, the person's own health or well-being
Austria (Federal Act of 3 July 1980 Amending the Narcotics Drugs Act)	Persons who on account of misuse of narcotic drugs require medical treatment or health supervision
Bangladesh (Narcotic Drugs and Psychotropic Substances Control Act, 1990)	Person often remains in a state of "abnormalcy" as a result of for being addicted to narcotics and his treatment is urgently necessary to bring him back to normal life
Bolivia (Law No. 1008 of 19 July 1998)	Consumer of controlled substance
Canada (British Columbia) (Heroin Treatment Act, 1979)	Person in need of treatment for narcotic dependence
Canada (Nova Scotia) (Narcotic Drug Addicts Act)	Person who is an "addict"

Table 8 *(continued)*

Country or territory	Grounds
Canada (Prince Edward Island) (The Addiction Services Act, dated 24 April 1981)	(*a*) Fourteen-day Appropriate Care and Treatment: person in a public place in or apparently in an intoxicated condition. A peace officer may take that person into custody. If it appears to a peace officer that the person may be in need of remedial treatment by reason of the abuse of alcohol or drugs, the peace officer must take that person to a treatment facility designated by the Minister of Health and Social Services (*b*) Treatment Order: where the Director is satisfied that: (i) a person taken into custody, is a chronic alcoholic; (ii) the person is in need of long-term care and rehabilitation; and (iii) no arrangements have been made for the voluntary treatment of that person, or if made are not likely to be adhered to by that person
China (Hong Kong)	Any person, or a young person, who is an addict and should be receiving treatment for his addiction
Colombia (Law 30 of 1986 (31 January) Adopting the National Narcotic Drugs Statute and enacting other provisions)	Persons who, without having committed any of the offences described in the Law, are affected by the consumption of dependence-producing drugs
Czech Republic (Law of 28 March 1989 on the Protection Against Alcoholism and Other Drugs)	Persons dependent on alcohol or other habit-forming drugs, if their state of health requires it

Table 8 *(continued)*

Country or territory	Grounds
Denmark (Law No. 349 of 14 May 1992 on the detention of drug-dependent persons undergoing treatment)	Drug dependent person who is an immediate risk to himself or others, who chooses to enter into a treatment contract. Detention may only be used in the absence of other more appropriate measures. A drug-dependent person may be detained when there are valid grounds for supposing that he will discontinue the agreed treatment, and that it would be irresponsible not to keep the person concerned in detention because: (1) the prospects of putting an end to his drug habit, or of substantially and decisively improving his condition, would be considerably reduced; and (2) the person concerned presents an immediate and considerable risk to himself or to others. Detention may only be used in the absence of other more appropriate measures
Germany (Bavaria) (Law of 20 April 1982 on the hospitalization of the mentally ill and their care)	Person who is mentally ill or suffering from psychiatric disturbance due to mental deficiency or addiction, and therefore represents a substantial danger to public safety and order or a grave danger to his own life or health.
Greece (Law No. 1729 of 3 August 1987 on combatting the spread of narcotics, protection of the young and other regulations)	Drug-dependent person
India (The Mental Health Act, 1987)	Mentally ill persons who are addicted to alcohol or other drugs which lead to behavioural changes in a person
Indonesia (Law No. 9 of 1976 on narcotics)	Adult or under-age narcotic addicts

Table 8 *(continued)*

Country or territory	Grounds
Iraq (Regulation No. 1 of 8 January 1981)	Drug-dependent person
Ireland (Mental Health Act, 1945)	Patient who is an addict and believed to require at least six months treatment to recover
Italy (Law No. 162 of 26 June 1990)	Anyone who personally uses narcotic and psychotropic substances
Japan (Narcotics and Psychotropics Control Law of 17 March 1953, as amended)	Narcotic addiction or suspicion of narcotic addiction
Japan (Mental Health Law of 1 May 1950)	Diagnosis of stimulant addiction, plus liable to injure himself or others because of addiction
Kenya (Mental Health Act, 1989)	Involuntary admission: person suffering from mental disorder and is likely to benefit by treatment in a mental hospital but is for the time being incapable of expressing himself as willing or unwilling to receive treatment Emergency admission: (i) any person whom applicant believes is suffering from mental disorder and who is found within the limits of his jurisdiction; and (ii) any person within the limits of his jurisdiction whom applicant believes is dangerous to himself or to others, or who, because of the mental disorder, acts or is likely to act in a manner offensive to public decency; and (iii) any person whom applicant believes to be suffering from mental disorder and is not under proper care and control, or is being cruelly treated or neglected by any relative or other person having charge of him

Table 8 *(continued)*

Country or territory	Grounds
Kuwait (Law No. 74/1983 of 18 April 1983)	Drug-dependent spouse, close relative; drug-dependent employee
Malaysia (Dangerous Drugs Act, as amended)	Person reasonably suspected of being drug-dependent
Mexico (Regulations of 7 January 1981 for the control of substances which are psychotropic when inhaled)	Minors addicted to substances which are psychotropic when inhaled
Myanmar (Narcotic drugs and Psychotropic Substances Law, State Law and Order Restoration Council Law No.1/93 of 27 January 1993)	A registered drug user. A drug user shall 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
New Zealand (Alcoholism and Drug Addiction Act, 1966, as amended)	Alcoholic (applies in the same way as to an alcoholic, to any person whose addiction to intoxicating, stimulating, narcotic or sedative drugs is causing or is likely to cause serious injury to his health or is a source of harm, suffering, or serious annoyance to others or renders him incapable of properly managing himself or his affairs).
Norway (Act No. 81 of 13 December 1991 relating to social services)	Person endangering his or her physical or mental health by extensive and lasting misuse, and if help (according to Section 6-1) is not sufficient, a decision can be taken that the person shall without his or her consent enter an institution for examination and the planning of treatment, and be kept there for up to three months

Table 8 *(continued)*

Country or territory	Grounds
Norway (Mental Health Act of 1961)	Person who abuses alcohol or other intoxicating or tranquillizing substance and is suffering from serious mental illness, if hospitalization will benefit patient, or is necessary for the public order or may prevent serious danger to himself or others
Peru (Law No. 22095 of 21 February 1978)	Drug addiction
Poland (Law No. 15 of 31 January 1985 on prevention of drug abuse)	Drug-dependent persons
Poland (Law of 26 October 1982 on education for sobriety and control of alcoholism)	Persons who, on account of abuse of alcohol, disrupt family life, adversely affect the morality of minors, are absent from work, and habitually commit breaches of the peace, must be examined by an expert who will establish whether they are alcohol-dependent and specify the appropriate kind of treatment centre
Portugal (Decree Law No.430/83 of 13 December 1983)	Drug addiction by virtue of consuming substances listed in the tables in the Decree
Russian Federation (Decree of 16 May 1985 on strengthening of measures to combat drunkenness)	Individual who has twice in the course of a year incurred an administrative penalty for the consumption of strong alcoholic beverages in public places or for appearance in public places in a drunken condition, is subject to fines or corrective labour

Table 8 *(continued)*

Country or territory	Grounds
Russian Federation (Law of 2 July 1992 of the Russian Federation on psychiatric care and the safeguarding of citizens' rights in the dispensing of such care)	Person suffering from serious mental disorders who: (*a*) constitutes an immediate danger to himself or those around him; (*b*) is helpless, i.e. incapable of meeting the basic requirements of day-to-day living on his own; or (*c*) will suffer substantial impairment of his health as a result of the deterioration of his mental state, if he is left without psychiatric care
Singapore The Misuse of Drugs Act of 16 March 1973)	Suspicion of drug addiction, and after medical examination or urine tests, it appears that treatment, rehabilitation, or both are necessary
Slovakia (Law No. 419/1991)	Patient by virtue of a mental disorder is a danger to himself or his associates and the circumstances are such that essential vital functions are threatened and it is necessary to take measures to preserve life and constantly monitor vital functions
South Africa (Prevention and Treatment of Drug Dependency Act, 1992)	A person who is dependent on drugs and in consequence thereof squanders his means or injures his health or endangers the peace or in any other manner does harm to his own welfare or the welfare of his family or fails to provide for his own support or for that of any dependent whom he is legally liable to maintain
Spain (Catalonia) (Law No. 20 of 25 July 1985)	Drug-dependent person
Sweden (The Care of Abusers (Special Provisions) Act/LVM/ (SFS 1988: 870) of 1 January 1989, as amended)	Person, as a result of a continuing misuse of alcohol, drugs or volatile solvents is in need of treatment in order to discontinue his misuse and the need for treatment cannot be satisfied in accordance with the provisions of the Social Services Act or in some other way and, as a consequence of his misuse: (1) he seriously endangers his physical or mental health: (2) he runs an obvious risk of destroying his life: or (3) it can be feared that he will inflict serious damage on himself or someone with whom he has a close relationship

Table 8 *(continued)*

Country or territory	Grounds
Sweden (The Care of Young Persons (Special Provisions) Act/LVU (SFS 1990:52) of 8 March 1990)	Two grounds: (*a*) Section 2 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 the young person's health or development being impaired (*b*) Section 3 provides that a care order must also be made if the 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
Sweden (Act on Detention of Intoxicated Persons (SFS 1976:511) of 10 June 1976)	Any person found in an indoor or outdoor public place, in a state of intoxication caused by alcoholic beverages or other intoxicants, may be detained by a policeman if his condition renders him unable to look after himself or otherwise dangerous to himself or to others
Switzerland (Geneva) (Law of 7 May 1981)	Where circumstances permit
Thailand (Rehabilitation of Narcotic Addicts Act B.E. 2534 (1991))	Any person who is accused of committing an offence on the charge of using or possessing a no. 1 or no. 5 narcotic in a quantity prescribed in a Ministerial Regulation and there is nothing to show that he/she is accused of or is in the process of having legal action instituted against him/her for another offence which is an offence for which the penalty is imprisonment or is subject to a judgement ordering imprisonment, must be sent by the interrogation officer to the rehabilitation centre which is inside his/her area of jurisdiction in order to verify whether that accused is addicted to narcotics or not

Table 8 *(continued)*

Country or territory	Grounds
Tonga (Mental Health Act 1992)	Person suffering from severe mental disorder ("alcoholic" or "drug addict") means a person suffering from a disorder or disability of the mind caused by his being so given over to or dependent on the use of alcohol or drugs that he is unable to control himself or is incapable of managing his affairs or endangers himself or others
Tunisia (Law No. 92-52 on Narcotics)	Drug dependence
United Kingdom (England and Wales) (Mental Health Act, 1983)	Person may not be involuntarily detained solely because of alcohol or drug dependence, but it is permissible to detain a person who is dependent upon alcohol or drugs if they are suffering from a mental disorder arising from or suspected to arise from alcohol or drug dependence or from the withdrawal from alcohol or a drug, if all other relevant conditions are met
United States of America (Federal) (Narcotic Addicts Rehabilitation Act of 1966, as amended (Public Law No. 89-793))	Persons addicted to narcotic drugs who are not charged with the commission of any offence
United States of America (Connecticut) (Chapter 319 of the State General Statutes, Alcohol and Drug Abuse (1993) (police assistance for an intoxicated person))	Person who appears to be intoxicated in a public place and in need of help

Table 8 *(continued)*

Country or territory	Grounds
United States of America (Connecticut) (Chapter 319 of the State General Statutes, Alcohol and Drug Abuse (1993) (protective custody for a person incapacitated by alcohol))	Person who appears to be incapacitated by alcohol
United States of America (Connecticut) (Chapter 319 of the State General Statutes, Alcohol and Drug Abuse (1993) (emergency treatment))	Intoxicated person who is (1) dangerous to himself or dangerous to others unless committed, (2) needs medical treatment for detoxication for potentially life-threatening symptoms of withdrawal from alcohol or drugs or (3) is incapacitated by alcohol
United States of America (Connecticut) (Chapter 319 of the State General Statutes, Alcohol and Drug Abuse (1993) (involuntary commitment of a drug-dependent person or an alcohol-dependent person))	An alcohol-dependent person or a drug-dependent person who is dangerous to himself or dangerous to others when he is an intoxicated person or who is gravely disabled
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Noncourt Involved Admissions: Protective Custody))	If a person in circumstances which justify protective custody as described in s. 397.677 fails or refuses to consent to assistance and a law enforcement officer has determined that a hospital or a licensed detoxification or addictions receiving facility is the most appropriate place for the person

Table 8 *(continued)*

Country or territory	Grounds
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Noncourt Involved Admissions: Emergency))	A person who meets the criteria for involuntary admission in s. 397.675 may be admitted to a hospital or to a licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization, or to a less intensive component of a licensed serviced provider for assessment only, upon receipt by the facility of the physician's certificate and the completion of an application for emergency admission
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Noncourt Involved Admissions and alternative involuntary assessment for minors))	In addition to protective custody, emergency admission, and involuntary assessment and stabilization, an addictions receiving facility may admit a minor for involuntary assessment and stabilization upon the filing of an application to an addictions receiving facility by the minor's parent, guardian, or legal custodian. The application must establish the need for involuntary assessment and stabilization based on the criteria for involuntary admission in s. 397.675
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Court Involved Admissions; Involuntary Assessment; Stabilization))	Person determined by the court to appear to meet the criteria for involuntary admission under s. 397.675
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Court Involved Admissions; Involuntary Treatment))	Person meets criteria for involuntary admission provided in s. 397.675 and: (1) has been placed under protective custody pursuant to s. 397.677 within the previous 10 days; (2) has been subject to an emergency admission pursuant to s. 397.679 within the previous 10 days; (3) has been assessed by a qualified professional within 5 days; (4) has been subject to involuntary assessment and stabilization pursuant to s. 397.6818 within the previous 12 days; or (5) has been subject to alternative involuntary admission pursuant to s. 397.6822 within the previous 12 days

Table 8 *(continued)*

Country or territory	Grounds
United States of America (Massachusetts) (Alcoholism Treatment and Rehabilitation Law of 1971, as amended)	Any person who is incapacitated (the condition of an intoxicated person who, by reason of the consumption of intoxicating liquors, is (1) unconscious; (2) in need of medical attention; (3) likely to suffer or cause physical harm or damage to property; or (4) disorderly)
United States of America (Massachusetts) (Chapter 123 of the General Laws)	Any person that a police officer, physician, spouse, blood relative or guardian reasonably believes to be an alcoholic, and there is a likelihood of serious harm as a result of his alcoholism
Venezuela (Resolution No. G-1112 of 16 June 1988)	Drug-dependent persons and potential drug users
Viet Nam (Constitution)	Addict
Zimbabwe (The Mental Health Act, 1976)	Patient who is mentally disordered or defective and is an inebriate

11.5 Medical examinations

Provisions governing medical examinations were found in 35 of the countries with compulsory commitment legislation (see Table 9). In general, the legislation requires such examinations to be conducted by one or more medically qualified persons designated variously as physicians, medical doctors, or medical practitioners. It is sometimes specified that medical doctors must be psychiatrists. In one country (South Africa), the examination may be conducted by a clinical psychologist, medical officer, or psychiatrist. In a few instances (South Africa), before a court may order compulsory commitment, a social work report on the social circumstances of the person must be submitted as part of the examination. In some countries (Czech Republic, Greece, Poland) medical specialists are not mentioned and examinations may instead involve laboratory tests (e.g. on urine, blood, saliva) to detect the presence of intoxicants such as alcohol and psychotropic drugs. The particular components of the laboratory tests may be specified in regulations of the ministry of health and social welfare. Laboratory

tests may be supplemented by a detailed clinical examination. In some legislation the examinations are required to result in specific findings. For example, in Canada (Prince Edward Island), the physician must be "satisfied": (*a*) that the person is in need of treatment by reason of alcohol or drug abuse; (*b*) the person should be detained in the interests of his own safety or the safety of others; and (*c*) no arrangements have been made for the voluntary treatment of the person, or if made, are unlikely to be adhered to. Legislation in some countries (Canada (Prince Edward Island), Thailand) requires that medical examinations must be conducted in accordance with publicly known procedures established by the ministry of health, or similar body. Such procedures are preferable to those left solely to the discretion of the examiner because uniformity is ensured and the court is assured that specific procedures are the basis of the findings. This tends to minimize the opportunity for abuse, and provides protection to persons whose liberty is at stake in civil commitment proceedings.

In Japan, the 1998 Ministry of Health and Welfare, Report on Administrative Measures Against Narcotics and Stimulants Abuse (Japan, 1998) states the medical examination procedure as follows:

> "When the relevant prefectural governor concludes that a person needs to undergo a medical examination in compliance with Paragraph 6, Article 58 of the Narcotics and Psychotropics Control Law (called here the "Law"), the person is instructed to see a designated physician of mental health. The physician decides whether or not the person needs hospitalization. The methods for medical examination are stipulated in Article 11, Enforcement Ordinance of the Law, while the standards are shown in Article 12 of the same ordinance. The human rights of the people in question need to be safeguarded, as compulsory hospitalization is accompanied by physical restraint. Accordingly, the purport of the law is to provide people who are truly in need of medical treatment with medical protection using appropriate medical examination methods and according to strict standards. At the same time, medical protection must be made widely available to narcotics addicts in order to prevent health and sanitary problems to safeguard the public welfare. Therefore, the system of compulsory hospitalization must be applied in an appropriate and smooth manner."

In most instances, either a "certificate" or a "report" must be prepared, reflecting the results of the medical examination. In a few countries (Bolivia, Colombia, Italy), persons who possess, in defined ("minimal") quantities, illicit drugs which they can prove are for their own personal use, must be medically examined by medical specialists to determine their daily consumption. In Bolivia, under Law No. 1008 of 19 July 1988, treatment and rehabilitation in a private or public institution depends on "a ruling by two experts" who must determine the minimum quantity for

immediate personal consumption for the person who is being detained. If the quantity possessed is greater than the minimum quantity, the punishment is imprisonment for 10-25 years, plus fines. In Italy, under Law No. 162 of 26 June 1990, anyone who possesses narcotic or psychotropic substances in doses not greater than the daily average requirement for personal use alone, calculated on the basis of the criteria set forth in the Law (Section 78 (1)), is subject to administrative sanctions, and treatment. The Minister of Health is required to issue a decree, establishing diagnostic and forensic medical procedures for ascertaining the habitual use of narcotic and psychotropic substances, the methods of quantifying the usual doses administered in a 24-hour period, and the maximum amounts for average daily doses. In Colombia, under Law 30 of 1986, anyone who carries on his person, keeps for his own use or consumes cocaine, marijuana, or any other dependence-producing drug in a quantity considered to be a dose for personal use, is subject to detention and a fine. In addition, a user or consumer who has been found for the first time to be in a state of drug addiction must be confined in a private or government-run psychiatric or similar establishment for the period necessary for his recovery; there is then no fine or detention. In Greece, the criteria for use in determining whether a person is dependent on narcotics are laid down in Ministry Regulation No. A2b/ik. 3982 of 7 October 1987, which establishes medical tests designed to determine whether narcotics have been used. These tests comprise a laboratory verification (toxicological analysis of body fluids) and a clinical examination.

Persons undergoing these tests are to be declared dependent on narcotics if they meet at least three of the following criteria:

- they consume narcotics in greater quantities and for a longer period of time than they intended;
- they have made repeated voluntary attempts, without success, to reduce or control consumption of narcotics;
- they spend a considerable part of their time in obtaining and consuming, or recovering from the effects of, narcotics;
- they are in a state of intoxication or display symptoms of the withdrawal syndrome from the drug, preventing satisfactory performance at work, school, etc;
- they discontinue important social, professional, or study activities by reason of consumption of narcotics;
- they continue to consume narcotics although aware of the chronic or long-term social, psychological, and physical problems thereby caused or aggravated;
- they require constantly increasingly quantities of the substances consumed;
- they display characteristic symptoms of the syndrome; and
- they frequently resort to narcotics to attenuate or overcome the symptoms of the syndrome.

The 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987) described procedures for medical examinations that we continue to recommend as countries assess and revise their legislation on drug- or alcohol-dependent persons. The

procedure should include a clinical examination and evaluation ordered by the court. The court will generally order the medical examination before a court hearing, either on an outpatient basis or during a short observational period in a residential centre or hospital. We suggest that the examination should be performed on an outpatient basis, preferably at a specialized community centre for drug- and alcohol-dependent persons, since such a centre would not have a bias towards the more restrictive commitment procedures. The medical examination should be completed and a report made to the court within 72 hours, wherever the examination is conducted. The examination and evaluation should always be performed at a facility staffed by personnel experienced in diagnosis and social evaluation and in the treatment of drug- and alcohol-dependent persons. The setting up of a specialized professional, medicolegal, or forensic psychiatric committee or board to conduct such examinations on behalf of the courts should also be considered.

The examination and evaluation should include an assessment of the patient's condition in terms of the statutory definition of drug or alcohol dependence and the legal grounds for civil commitment. The report should indicate whether the patient has been subject to less restrictive measures and the likelihood of successful treatment with the different methods of treatment available.

Table 9 lists [1] the medical requirements (see Annex A2.1) for compulsory civil commitment in various countries and territories.

Table 9

Provisions governing medical requirements for compulsory civil commitment [1]

Country or territory	Medical requirements
Australia (Queensland) (Liquor Act 1992)	Council may issue to the person a notice to show cause on a day at a time and place specified in the notice, why the person should not be subject to a prohibition order. Cause may be shown by oral or written submission made in person by the person called on to show cause
Austria (Federal Act of 3 July 1980 Amending the Narcotics Drugs Act 1980)	If certain facts indicate that a person is abusing narcotic drugs, the district administration board acting as health authority must obtain medical expert opinion on him or her by a doctor sufficiently conversant with problems of drug abuse. The person concerned must undergo the medical examination necessary for this purpose

Table 9 *(continued)*

Country or territory	Medical requirements
Bangladesh (Narcotic Drugs and Psychotropic Substances Control Act, 1990)	If it appears to any physician that any person under his treatment is addicted to narcotics which requires treatment he must advise the addicted person about such treatment and must also inform the Director General in writing regarding the necessity of such treatment. Moreover, 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
Bolivia (Law No. 1008 of 19 July 1988 of the Regime Applicable to Coca and controlled substances)	Institutes (for research, prevention, treatment and rehabilitation) must evaluate the condition of drug-dependent persons or drug addicts brought to the establishment and provide all technical information required by a competent authority
Canada (British Columbia) (Heroin Treatment Act, 1979)	edical and psychological examination of person by an valuation panel consisting of at least two medical ractitioners and one other person from an official list to etermine need for treatment
Canada (Nova Scotia) (Narcotic Drug Addicts Act)	inister of Public Health is credibly informed that erson is addicted

Table 9 *(continued)*

Country or territory	Medical requirements
Canada (Prince Edward Island) (The Addiction Services Act, dated 24 April 1981)	For 14-day appropriate care and treatment, a person taken to a treatment facility, must be medically examined and assessed. If satisfied to the following, physician may issue a certificate to that effect: (*a*) the person is in need of treatment by reason of his abuse of alcohol or drugs; (*b*) the person should be detained in the interests of his own safety or the safety of others; and (*c*) no arrangements have been made for the voluntary treatment of the person, or if made, are unlikely to be adhered to
China (Hong Kong) (Drug Addiction Treatment Centres Ordinance, Chapter 326 of the Revised Edition, 1989, Ordinance No. 34 of 1960)	Not stated
Colombia (Law 30 of 1986 (31 January) Adopting the National Narcotic Drugs Statute and enacting other provisions)	A user or consumer who, in accordance with forensic medical opinion, is in a state of drug addiction, having been found so for the first time. Entrance to an establishment and termination of treatment require favourable medical examination
Czech Republic (Law No. 548/1991, amending Law No. 20/1966 on the protection of public health)	The person concerned shows symptoms of mental illness or intoxication that constitute a danger to himself or to those around him
Denmark (Law No. 349 of 14 May 1992 on the detention of drug-dependent persons undergoing treatment)	It would be irresponsible not to keep the person concerned in detention for the following reasons: (1) the prospect of putting an end to his drug habit, or of substantially and decisively improving his condition, would be considerably reduced; and (2) the person concerned presents an immediate and considerable risk to himself and others

Table 9 *(continued)*

Country or territory	Medical requirements
Germany (Bavaria) (Law on the hospitalization of the mentally ill and their care of 20 April 1982)	The expert opinion of a medical practitioner of the health authority is required, and the practitioner must also explain why hospitalization cannot be avoided through other remedies
Greece (Law No. 1729 of 3 August 1987, Combating the spread of narcotics, protection of the young and other regulations)	Ministry regulation No. A2b/ik. 3982 of 7 October 1987 establishes medical tests. The test to determine whether narcotics have been used is a laboratory verification (toxicological analysis of body fluids) and a clinical examination (supplementary detailed examination)
Indonesia (Law No. 9 of 1976 on narcotics)	Not stated
Iraq (Regulation No.1 of 8 January 1981)	Involuntarily admitted patients are subject to examination by the medical committee of the centre or hospital
Ireland (Mental Health Act, 1945)	A patient: (*a*) who is: (I) suffering from mental illness: and (ii) is believed to require, for his recovery, not more than six months suitable treatment, and (iii) is unfit on account of his mental state for treatment as a voluntary patient, or (*b*) who is : (i) an addict, and (ii) is believed to require, for his recovery, at least six months preventive and curative treatment
Italy (Law No. 162 of 26 June 1990)	Persons exercising the medical profession assisting persons addicted to the use of narcotic and psychotropic substances, shall forward to the public drug-dependence service a health record containing the personal particulars of the patient, including the occupational, educational level, medical history and diagnosis, and the results of tests and treatment. Those who request anonymity are entitled to ensure that their health records do not contain any personal particulars or data which might be used to identify them

Table 9 *(continued)*

Country or territory	Medical requirements
Japan Narcotics and Psychotropics Control Law of 17 March 1953, as amended)	Medical examiner of mental health diagnoses addiction and high probability of repeated abuse if not hospitalized
Japan (Mental Health Law of 1 May 1950)	Medical examiner of mental health diagnoses mental disorder and agrees person is liable to injure self or others
Kenya (The Mental Health Act, 1989)	Before signing a recommendation, the medical practitioner must examine the person and specify in the recommendation the date or dates on which he examined the person and the grounds on which the recommendation is based
Malaysia (Dangerous Drugs Act, as amended)	Medical officer at a detention centre, after examination or observation, concludes that person can be certified to be drug dependent
Mexico (Regulations of 7 January 1981 for the control of substances which are psychotropic when inhaled)	Not stated
Myanmar (Narcotic Drugs and Psychotropic Substances Law of 27 January 1993)	Actions taken under this Law must be in accordance with laboratory analysis in respect of narcotic drugs and psychotropic substances

Table 9 *(continued)*

Country or territory	Medical requirements
New Zealand (Alcoholism and Drug Addiction Act, 1966, as amended)	District Court Judge must not make an order for detention unless two medical practitioners either give evidence to the effect or give certificates in the prescribed form to the effect that they believe the alleged alcoholic to be an alcoholic within the meaning of this Act and that the making of an order for his detention and treatment as such is expedient in his own interest or that of his relatives
Norway (Act No. 81 of 13 December 1991 relating to social services)	Not stated
Norway (Mental Health Act of 1961)	If the doctor, following personal examination, considers it necessary, the patient — at the request of his nearest relatives or the public authority — may be permissibly hospitalized or detained in some other place where proper care can be provided
Peru (Law No. 22095 of 21 February 1978)	The condition of the drug addict is determined only after an examination by a medicolegal physician at the request of the competent judge. This examination takes into account: (*a*) the nature and amount of substances that produced the dependence; and (*b*) the history and clinical situation of the person
Poland (Law No. 15 of 31 January 1985 on Prevention of Drug Abuse)	The Minister of Health and Social Welfare defines the principles of organization of laboratory tests devised to detect the presence of intoxicants and psychotropic drugs

Table 9 *(continued)*

Country or territory	Medical requirements
Poland (Law of 26 October 1982 on education for sobriety and control of alcoholism, as amended)	(*a*) To determine if alcohol-dependent. When the court orders testing by a recognized expert on observation in a centre, the person whom the proceeding concerns is obliged to submit to psychological and psychiatric tests and the actions necessary to conduct the elementary laboratory analysis, provided they do no harm and are in keeping with proper medical knowledge. The Minister of Health and Social Welfare, together with the Minster of Justice in a ruling must determine the manner of recognizing qualified experts, drafting opinions and the manner and way of carrying out the tests (*b*) Compulsory treatment. For failure to appear for medical examination or at trial, the court may order the person to be detained by the citizens militia, for treatment, but only as necessary to fulfil the order
Portugal (Decree Law No. 430/83 of 13 December 1983)	Examination by a doctor or expert from the Centre for Drug Prophylaxis
Russian Federation (Decree of 16 May 1985 on strengthening of measures to combat drunkenness)	Not stated

Table 9 *(continued)*

Country or territory	Medical requirements
Russian Federation (Law of 2 July 1992 of the Russian Federation on psychiatric care and the safeguarding of citizens' rights in the dispensing of such care)	Persons committed to a psychiatric hospital on the grounds provided by Section 29 of this Law (i.e. compulsory commitment to a psychiatric hospital), shall be compulsorily examined within 48 hours by the commission of psychiatrists of the psychiatric establishment, it being the task of the commission to decide whether commitment is justified. If commitment is deemed unjustified and if the patient does not wish to remain in the psychiatric hospital, he must be discharged immediately. If commitment is deemed justified, the report of the commission of psychiatrists must be submitted within 24 hours to the court whose jurisdiction covers the psychiatric establishment concerned, in order that a decision may be taken with regard to the person's continued stay in the establishment
Singapore (The Misuse of Drugs Act of 16 March 1993)	Government medical officer or medical practitioner medically examines or observes person to determine whether treatment appears necessary
Slovakia (Law No. 419/199)	Until court decides on the legality of commitment, permissible to carry out any medical examinations and procedures necessary to preserve life and health of patient or to protect the persons around him
South Africa (Prevention and Treatment of Drug Dependency Act, 1992)	Magistrate must, before making any order of detention, direct the public prosecutor or other person appearing at the inquiry to submit a report from a social worker as to the social circumstances of the person concerned and any other relevant matter affecting him. The magistrate may direct that the person in respect of whom the inquiry is being held be examined by a medical officer, psychiatrist or clinical psychologist designated by the magistrate and cause all steps including the use of force which may be necessary for the carrying out of such examination to be taken and may call upon the medical officer, psychiatrist or clinical psychologist to furnish him with a report showing the results of the examination

Table 9 *(continued)*

Country or territory	Medical requirements
Spain (Catalonia) (Law No. 20 of 25 July 1985 on prevention and care in regard to potentially dependence producing substances)	Not stated
Sweden (The Care of Abusers (Special Provisions) Act/LVM/ (SFS 1988:870) including amendments up to and including SFS 1994: 96, entered into force on 1 July 1994	Where an investigation has been initiated, the County Administration shall, unless it is manifestly unnecessary, decide on a medical examination of the misuser and designate the doctor who shall undertake it. The doctor shall report on the misuser's current state of health in a certificate
Sweden (The Care of Young Persons (Special Provisions) Act/LVU (SFS 1990:52) of 8 March 1990)	The social welfare committee may order the medical examination of the young person and appoint a physician to carry out the examination. If it is inappropriate for the examination to be conducted in the young person's home, the committee may fix another venue. In judicial proceedings under this Act, the same powers are vested in the court. A medical examination must take place before the committee makes an application as provided, unless it is superfluous for particular reasons
Sweden (Act on Detention of Intoxicated Persons (SFS 1976:511) of 10 June 1976	If his condition so requires, the person must undergo a medical examination as soon as possible and, if necessary, be hospitalized

Table 9 *(continued)*

Country or territory	Medical requirements
Switzerland (Geneva) (Law of 7 May 1981)	Guardianship Court, or the magistrate to whom task has been delegated, may invite the person concerned to accept counselling from a social service or to undergo a medical examination. The Court or the magistrate must endeavour to persuade the person concerned to follow the recommended treatment or to take any other appropriate preventive measures
Thailand (Rehabilitation of Narcotic Addicts Act B.E. 2534)	A verification examination to determine whether the accused is addicted to narcotics or not. The criteria and procedures for the verification examination are prescribed in Ministerial Regulations
Tonga (Mental Health Act 1992)	(*a*) Observation: Magistrate may make observation order only when satisfied by sworn evidence that (i) such person is suffering from mental disorder of a nature and degree which warrants his detention in hospital for observation (with or without medical treatment); and (ii) the order is necessary in the interests of that person or some other person (*b*) Treatment: The order shall not be made unless the Supreme Court is satisfied by sworn evidence (i) that such person is suffering from mental disorder of a nature and degree which warrants his detention in hospital for medical treatment; and (ii) the order is necessary in the interests of the patient or some other person
Tunisia (Law No. 92-52 on Narcotics)	Medical certificate
United States of America (Federal) (Narcotic Rehabilitation Act of 1966, as amended (Public Law No. 89-793))	Examining physicians conclude person is a narcotic addict and likely to be rehabilitated through treatment

Table 9 *(continued)*

Country or territory	Medical requirements
United States of America (Connecticut) (Chapter 319 of the State General Statutes, Alcohol and Drug Abuse (1993) (police assistance for an intoxicated person))	Not stated
United States of America (Connecticut) (Chapter 319 of the State General Statutes, Alcohol and Drug Abuse (1993) (protective custody for a person incapacitated by alcohol))	Person brought to a treatment facility which provides medical triage, or to a hospital must be examined by a medical officer or his designee as soon as possible to determine whether the person requires inpatient treatment based upon the medical examination of the person and upon a finding that the person is incapacitated by alcohol
United States of America (Connecticut) (Chapter 319 of the State General Statutes, Alcohol and Drug Abuse (1993) (emergency treatment))	Application for commitment must state facts to support the need for emergency treatment and be accompanied by a physician's certificate stating that he has examined the person sought to be committed within two days before the certificate's date and facts supporting the need for emergency treatment

Table 9 *(continued)*

Country or territory	Medical requirements
United States of America (Connecticut) (Chapter 319 of the State General Statutes, Alcohol and Drug Abuse (1993) (involuntary commitment of a drug dependent person or an alcohol dependent person))	Petition must be accompanied by a certificate of a licensed physician who has examined the person within two days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The physician's certificate must set forth the physician's findings, including clinical observation or information, or the person's medical history, in support of the allegation of the petition, and a finding of whether the person presently needs and is likely to benefit from treatment, and shall include a recommendation as to the type and length of treatment and inpatient facilities available for such treatment. A physician employed by the private treatment facility to which the person is to be committed is not eligible to be the certifying physician. A petition filed by a person other than the certifying physician shall set forth the facts and information upon which the petitioner bases his allegations and the names and addresses of all physicians and of any witnesses believed have knowledge of the material facts
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Noncourt Involved Admissions: Protective Custody))	Persons taken into protective custody must be assessed by the attending physician within 72 hours and without unnecessary delay, to determine the need for further services

Table 9 *(continued)*

Country or territory	Medical requirements
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Noncourt Involved Admissions: Emergency))	The physician's certificate for emergency admission must include the name of the person to be admitted, the relationship between the person and the physician, the relationship between the applicant and the physician, any relationship between the physician and the licensed service provider and a statement that the person has been examined and assessed within 5 days of the application date, and must include factual allegations with respect to the need for emergency admission, including: (*a*) the reason for the physician's belief that the person is substance abuse impaired; and (*b*) the reason for the physician's belief that because of such impairment the person has lost the power of self control with respect to substance abuse; and either: (*c*)1. The reason the physician believes that the person has inflicted or is likely to inflict physical harm on himself or others unless admitted; or 2. the reason the physician believes that the person's refusal to voluntarily receive care is based on judgement so impaired by reason of substance abuse that the person is incapable of appreciating his need for care and of making a rational decision regarding his need for care. 2. The physician's certificate must recommend the least restrictive type of service that is appropriate for the person. The certificate must be signed by the physician. 3. A signed copy of the physician's certificate must accompany the person, and must be made a part of the person's clinical record, together with a signed copy of the application. The application and the physician's certificate authorize the involuntary admission of the person pursuant to, and subject to the provisions of ss. 397.679-397-6797. 4. The physician's certificate must indicate whether the person requires transportation assistance for delivery for emergency admission and specify, pursuant to s. 397.6795, the type of transportation assistance necessary

Table 9 *(continued)*

Country or territory	Medical requirements
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Noncourt involved admissions and alternative involuntary assessment for minors))	An addictions receiving facility may admit a minor for involuntary assessment and stabilization upon the filing of an application to an addictions receiving facility by the minor's parent, guardian, or legal custodian. The application must establish the need for involuntary assessment and stabilization based on the criteria for involuntary admission in s. 397.675
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Court Involved Admissions; Involuntary Assessment; Stabilization))	To a hospital or to a licensed detoxification facility or addictions receiving facility, for involuntary assessment and stabilization or to a less restrictive component of a licensed service provider for assessment only upon entry of a court order or upon receipt by the licensed service provider of a petition Section 397. 6819 (Involuntary assessment and stabilization; responsibility of licensed service provider). A licensed service provider may admit a client for involuntary assessment and stabilization for a period not to exceed 5 days. The client must be assessed without unnecessary delay by a qualified professional. If an assessment is performed by a qualified professional who is not a physician, the assessment must be reviewed by a physician prior to the end of the assessment period
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Court Involved Admissions; Involuntary Treatment))	At a hearing on a petition for involuntary treatment, the court must hear and review all relevant evidence, including the review of results of the assessment completed by the qualified professional in connection with the respondent's protective custody, emergency admission, involuntary assessment, or alternative involuntary admission
United States of America (Massachusetts) (Alcoholism Treatment and Rehabilitation Law of 1971, as amended))	Police officer may request the person to submit to reasonable tests of coordination, coherency of speech and breath to determine if person is intoxicated

Table 9 *(continued)*

Country or territory	Medical requirements
United States of America (Massachusetts) (Chapter 123 of the General Laws)	Court must order an examination by a qualified physician
Venezuela (Resolution No. G-1112 of 16 June 1988)	Not stated
Viet Nam (Constitution)	Not stated
Zimbabwe (The Mental Health Act, 1976)	No reception order may be granted unless each medical certificate shows that the medical practitioner has personally examined the patient not more than 14 days before the date of the reception order; and contains the particulars required by subsection (1) of Section 20 of the Act. Section 20 provides that medical practitioner giving a medical certificate must, in addition to the facts indicating mental disorder or defect in the patient, also indicate other facts observed by him, such as the reasons why he considers it necessary in the interest of the health and safety of the patient or for the protection of other persons that the patient should be detained in an institution

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

11.6 Length of stay and periodic review

A review of the provisions governing length of stay in compulsory civil commitment reveals an extremely wide range of periods of treatment, from not more than eight hours to an indefinite term. These differences appear to be related primarily to the purposes of treatment, which include: (*a*) short-term emergency assistance or treatment for alcohol dependence (e.g. Japan, Sweden); and (*b*) medium-term periods of treatment, ranging from several days to six months, for drug or alcohol dependence. Provisions for involuntary civil commitment for an indefinite term is not recommended

because of the clear potential to violate individual liberty protections. Even so, in some jurisdictions, the length of stay is indefinite, and depends on the outcome, e.g. until no longer needed (Austria); until such time as certainty regarding rehabilitation has been established (Bolivia); until cured (Canada, Prince Edward Island); and until recovery (Colombia). For after-care following treatment, a period of two years is prescribed in Malaysia.

Legislation in some countries makes periods of confinement mandatory, but compulsory civil commitment is justified only when an effective treatment programme, as well as adequate and humane facilities, are available. The duration of such confinement should be limited, as already pointed out, and a person's involuntary status subject to periodic review, linked to the reason and need for involuntary commitment for care or treatment. Many jurisdictions provide separate legislation geared to different needs. For example, in Sweden, for emergency care under the Act on Detention of Intoxicated Persons (SFS 1976:511) of 10 June 1976, a person may "not normally be detained for longer than eight hours". Under the provisions of the Care of Abusers (Special Provisions) Act/LVM/ (SFS 1988:870) of 1 January 1989, as amended, compulsory treatment "shall cease as soon as the purpose of the treatment is achieved and at the latest when treatment has been undertaken for six months". Also in Sweden, under the provisions of the Care of Young Persons (Special Provisions) Act/LVU, (SFS 1990:52) of 1 July 1990, the frequency of review is at least once every six months.

The person concerned should be afforded certain substantive and procedural legal rights during the commitment proceedings. In some countries, these include the rights to timely judicial hearing; adequate and timely notice of the proceedings; counselling at an appropriate time; immunity from self-incrimination; confrontation and cross-examination of any witnesses; a standard of proof requiring substantial evidence to be produced by the State; effective and humane treatment; and meaningful and adequate review.

Periodic review is the responsibility of a variety of bodies, including judges or courts (Czech Republic, Poland, Russian Federation), boards of visitors or addiction review bodies (Canada (Prince Edward Island, Malaysia, Norway) or the person in charge of the treatment facility (Kenya). The frequency of such reviews varies from "periodic" to every six months.

Table 10 lists the length of stay, frequency of periodic review, and the body or persons responsible for conducting the review in various countries and territories.

Table 10

Length of stay and frequency of review in compulsory civil commitment [24]

Country or territory	Length of stay	Frequency of review and by whom conducted
Australia (Queensland) (Liquor Act 1992)	One year, or shorter period specified in prohibition order, unless sooner rescinded on appeal	Court's decision (regarding appellant's appeal) does not prevent making of another prohibition order at subsequent time
Austria (Federal Act of 3 July 1980)	Indefinite, as long as the said situation prevails	Not stated
Bolivia (Law No. 1008 of 19 July 1988)	Indefinite: until such time as certainty regarding their rehabilitation has been established; for entire period which the specialist doctor considers necessary	Confirmation by specialist
Canada (Nova Scotia)	Indefinite, continue such treatment until cured	Not stated
Canada (Prince Edward Island) (The Addiction Services Act, dated 24 April 1981)	(*a*) Fourteen day appropriate care and treatment: not more than 14 days. (*b*) Treatment order: Not exceeding six months.	Addiction Review Board, composed of three members, one of whom is a Supreme Court judge and acts as chairman, and one is a physician

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

Table 10 *(continued)*

Country or territory	Length of stay	Frequency of review and by whom conducted
China (Hong Kong) (Drug Addicts Treatment and Rehabilitation Ordinance). Chapter 326 of the Revised Edited 1989 (Ordinance No. 34 of 1960)	Period of six months, or in the case of a young person, 12 months from the date of his first admission to a centre	Addiction Treatment Centre Appeal Board
Colombia (Law 30 of 31 January 1986)	Not stated (in accordance with Decree 1136 of 1970)	Not stated (in accordance with Decree 1136 of 1970)
Czech Republic (Law of 28 March 1989 on the Protection against Alcoholism and other Drugs)	Not stated	The decision concerning a duty to undergo institutional care will be reviewed by a court if the proposal was made by the person concerned, by his guardian or by a person close to him.
Denmark (Law No. 349 of 14 May 1992)	Maximum of six months	Not stated
Germany (Bavaria) (Law of 20 April 1982)	Not to exceed six months	Every six months
Iraq (Regulation No. 1 of 8 January) 1981)	Between 30 and 90 days	Not stated
Italy (Law No. 162 of 26 June 1990)	Three years for drug-addicted workers, in treatment	Not stated

Table 10 *(continued)*

Country or territory	Length of stay	Frequency of review and by whom conducted
Japan (Narcotics and Psychotropics Control Law of 17 March 1953, as amended)	Not more than 30 days	Administrator of hospital may submit request for further term to Narcotic Addiction Examination Committee
Japan (Mental Health Law of 1 May 1950)	Not more than 48 hours	Administrator of mental hospital reports to Governor of Prefecture if he believes person not liable to injure self or others due to mental disorder even if not hospitalized
Kenya (The Mental Health Act, 1989)	(*a*) Voluntary patient: 72 hours notice in writing of his intention to leave (*b*) Involuntary patient: not exceeding period of six months, which period may be extended, but any continuous period may not exceed twelve months (*c*) Emergency admission: not exceeding 72 hours	(*a*) Voluntary patient: Person in charge must review the condition of the patient or cause the condition to be reviewed within the 72-hour period (*b*) and (*c*) Involuntary patients: the Board may at any time order that the person be discharged or otherwise dealt with under this Act
Malaysia (Drug Dependents (Treatment and Rehabilitation) Act, 1983)	(*a*) Court order: period of not less than two and not more than three years (*b*) Voluntary: two years and thereafter under after-care; or under probation for not less than two years and not more than three years	The Board of Visitors of a rehabilitation centre may shorten the period of residence at such centre in respect of any person for reasons which appear to it to be sufficient if such person has already completed a period of 12 months residence at such centre

Table 10 *(continued)*

Country or territory	Length of stay	Frequency of review and by whom conducted
New Zealand (Alcoholism and Drug Addiction Act, 1966, as amended)	Not more than two years	After six months, any patient may request discharge; judge may order examination pursuant to request
Norway (Act No. 81 of 13 December 1991 relating to Social Services)	(*a*) Voluntary: up to three weeks (*b*) For the purpose of treatment or training for at least three months; the condition can also be stipulated that the misuser can be kept there for up to three weeks after the consent has been expressly withdrawn. Such retention can only take place up to three times in each stay	Not stated
Poland (Law of 26 October 1982 on education for sobriety and control of alcoholism, as amended).	(i) Sobering-up centres: detained until sober, for a period not exceeding 24 hours. The premises for detaining person under 18 years of age must be separate from those used for adults (ii) Compulsory treatment: not longer than two years.	A judge may enter, at any time, an inpatient medical centre or a social assistance home to verify that the persons concerned are duly undergoing treatment on the facility and to investigate the conditions of their stay. After compulsory treatment is concluded, ruling on application in respect of the same person cannot be made by the court until three months after the completion of compulsory treatment.

Table 10 *(continued)*

Country or territory	Length of stay	Frequency of review and by whom conducted
Poland (Law No. 15, of 31 January 1985, on Prevention of Drug Abuse)	Shall not be determined in advance, but may not exceed two years	Not stated
Portugal (Decree Law No. 430/83 of 13 December 1983)	As long as necessary for the recovery of drug-addicted person	Centre of Drug Prophylaxis or institution in charge must report every three months to the court on the development of the patient. Information is kept confidential. Centre may suggest suitable measures (e.g. end of treatment; replacement by voluntary treatment)
Russian Federation (Decree of 16 May 1985 of the Presidium of the Supreme Soviet of the USSR on the strengthening of measures to combat drunkenness (acceded to by the Russian Federation))	Period between one and two months; repetition of acts stated as grounds above, or other actions enumerated in the Decree, shall be punished by imprisonment for up to two years, or by corrective labour for a period of between one and two years	Any person who has committed an administrative contravention shall be released from administrative liability and the facts of the case must be handed over for consideration to a comradely court, social organization, or worker's collective, if it is clear that social action would be appropriate

Table 10 *(continued)*

Country or territory	Length of stay	Frequency of review and by whom conducted
Russian Federation (Law of 2 July 1992 of the Russian Federation on psychiatric care and safeguarding of citizens' rights in the dispensing of such care)	Six months, then after examination, commitment can be extended, in six-month periods, subject to report to be submitted to the court, by a commission of psychiatrists on the need for continued commitment. May only be extended for as long as the grounds that justified his commitment remain valid	A person compulsorily committed to a psychiatric hospital shall be examined at least once a month during the first six months by the commission of psychiatrists of the psychiatric establishment. If the commitment is extended beyond six months, the commission must examine the person at least once every six months
Singapore (The Misuse of Drugs Act of 16 March 1973)	Six months, unless discharged earlier, or further six-month periods, but not more than a total of three years	Review Committee, as often as practicable, considers whether person should be discharged. The director of the Central Narcotics Bureau or the Review Committee may order discharge or transfer to other institutions.

Table 10 *(continued)*

Country or territory	Length of stay	Frequency of review and by whom conducted
South Africa (Prevention and Treatment of Drug Dependency Act, 1992 of 3 March 1992)	Until released on licence or discharged or transferred or returned to any other institution under terms of this Act	If a patient has, after 12 months not yet been discharged from the treatment centre or registered treatment centre concerned must report fully to the Director-General and advance reasons why the patient has not been discharged and must, after every six months thereafter, if the patient has not been so discharged, advance further reasons why he should not be discharged
Sweden (The Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents (Special Provisions) Act/LVM/ (SFS 1988:870) of 1 January 1989, as amended)	Coercive treatment shall cease as soon as the purpose of the treatment is achieved and at the latest when treatment has been undertaken for six months (period of treatment)	Decisions on admission to and discharge from an LVM home are to be taken by the governing body or the person in charge of treatment at the home

Table 10 *(continued)*

Country or territory	Length of stay	Frequency of review and by whom conducted
Sweden (The Care of Young Persons (Special Provisions) Act/LVU (SFS 1990:52) of 8 March 1990)	Not stated	At least once every six months, whether care under the Act is still necessary
Sweden (Act on Detention of Intoxicated Persons (SFS 1976:511) of 10 June 1976)	The person may not normally be detained for longer than eight hours	Not stated
Switzerland (Geneva) (Law of 7 May 1981)	Not stated	The person concerned, his family or relatives, his guardian, his curator, his legal adviser, his lawyer, the physician in charge of the establishment, or the director of the establishment may at any time submit a request to the Guardianship Court that the commitment be terminated; the Court must reach a decision within three working days
Tonga (Mental Health Act 1992)	(*a*) Observation: not exceeding 28 days, but magistrate, may renew the order from time to time for periods not exceeding 28 days (*b*) Treatment: not exceeding two years, but Supreme Court may renew the order from time to time for periods not exceeding two years	Not stated

Table 10 *(continued)*

Country or territory	Length of stay	Frequency of review and by whom conducted
United States of America (Federal) (Narcotic Addict Rehabilitation Act of 1966, as amended)	Six months as inpatient; up to three years in community rehabilitation	After three months in confinement, upon petition of person, could inquire into health and general conditions of patient and need for continued confinement
United States of America (Connecticut) (Chapter 319 of the State General Statutes, Alcohol and Drug Abuse (1993) (police assistance for an intoxicated person))	Not stated	Not stated
United States of America (Connecticut) (Chapter 319 of the State General Statutes, Alcohol and Drug Abuse (1993) (protective custody for a person incapacitated by alcohol))	Person must be released once no longer incapacitated by alcohol or within 48 hours, whichever is shorter, unless person consents to further medical evaluation or treatment	Not stated
United States of America (Connecticut) (Chapter 319 of the State General Statutes, Alcohol and Drug Abuse (1993) (emergency treatment))	Not more than five days, unless a petition for involuntary commitment has been filed within the five-day period and grounds are found for commitment; person may then be detained until petition heard but no longer than five business days after filing of petition	Not stated

Table 10 *(continued)*

Country or territory	Length of stay	Frequency of review and by whom conducted
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Noncourt Involved Admissions: Protective Custody))	A client may only be retained in protective custody beyond the 72-hour period when a petition for involuntary assessment or treatment has been initiated	Not stated
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Noncourt Involved Admissions: Emergency))	Up to five days	Not stated
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Noncourt Involved Admissions and alternative involuntary assessment for minors))	Not stated	Not stated
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Court Involved Admissions; Involuntary Assessment; Stabilization))	Period of five days	If a licensed service provider is unable to complete the involuntary assessment and, if necessary, stabilization of a client within five days after the court's order, it may, within the original time period, file a written request of an extension of time to complete its assessment, and shall, in accordance with confidentiality requirements, furnish a copy to all parties

Table 10 *(continued)*

Country or territory	Length of stay	Frequency of review and by whom conducted
United States of America (Florida) (Alcohol and Other Drug Services Act of 1993 (Court Involved Admissions; Involuntary Treatment))	Period not to exceed 60 days	Whenever a service provider believes that a client who is nearing the scheduled date of release from involuntary treatment continues to meet the criteria for involuntary treatment, a petition for renewal of the involuntary treatment order may be filed with the court at least 10 days prior to the expiration of the court ordered treatment period
United States of America (Massachusetts) (Treatment and Commitment of Mentally Ill and Mentally Retarded Persons) Chapter 123 of the General Laws	Not to exceed 15 days	Not stated
United States of America (Massachusetts) Chapter IIIB of the General Laws (Alcoholism Treatment and Rehabilitation Law of 1971, as amended); Assistance of an incapacitated person to a facility	At a police station until no longer incapacitated, or 12 hours, whichever is shorter	Not stated

Table 10 (continued)

Country or territory	Length of stay	Frequency of review and by whom conducted
United States of America (Massachusetts) Chapter IIIB of the General Laws (Alcoholism Treatment and Rehabilitation Law of 1971, as amended); Admission to a facility, aftercare, etc.	Up to 48 hours	Not stated
Venezuela (Resolution No. G112 of 16 June 1988)	Therapeutic process and the social reintegration of the persons concerned to continue for a period of at least two years	Preparation, every six months, of an evaluation report on the activities of the centre
Zimbabwe (The Mental Health Act, 1976)	(*a*) Reception Order: not exceeding six weeks; (*b*) Judge's Order: at Judge's discretion	Superintendent must transmit to the Secretary for the first three years annually; and thereafter in the sixth year and subsequently every five years, a report on the mental and physical condition of patients

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

In many countries (e.g. the United States of America), in an effort to reduce costs, the government or other insurance agency paying for the treatment has lowered the coverage of, or the extent to which the cost of alcohol treatment is reimbursed. As a consequence, there has been a tendency for the duration of treatment to be reduced. For example, for alcohol treatment in the United States of America the standard was formerly 28 days, but the tendency in recent years has been to reduce this to 14 days.

The 1987 WHO guidelines (Curran, Arif & Jayasuriya, 1987) made a number of recommendations concerning both the duration of residential commitment, and periodic review. These are reproduced, in part, below.

The duration of longer-term, compulsory residential commitment should be specified in the primary legislation. Such commitment sometimes includes much longer periods of supervised community after-care. The director of the residential treatment centre should be authorized to discharge the person to the community at any time, under a supervised after-care programme, but only with the permission of the court. If the supervised discharge fails and the person again requires residential care, the detention may, of course, be renewed under various alternative procedures. In national treatment programmes, efforts must always be made to use scarce resources and manpower in the most effective and productive fashion.

With regard to review procedures for each compulsory procedure, the legislation should lay down the requirements for court review; these should be essentially the same for direct court application for longer-term residential commitment and for appeals by the drug-dependent person in the less restrictive compulsory alternatives.