

CHAPTER 5. POLICY AND LEGISLATION

5.1 Alcohol and drug treatment policy in public health perspective

Robin Room

For centuries, physicians, clergy and charity workers have provided treatment or care for habitual use of alcohol or drugs. But the treatment was provided as part of their general practice of caring. Specialized institutions and professionals for the treatment of alcohol disorders first emerged in the 1800s and spread through more industrialized and urbanized countries (Baumohl & Room, 1987). The initial institutions tended to take one of two forms: small "homes", often run under religious auspices, and larger "inebriates' asylums", run under medical auspices. Treatment was predominantly inpatient, and often lasted for a year or longer. Patients in inebriates' asylums were often there under a judicial civil commitment order. By 1900, many such institutions were also taking cases with opiate and other drug disorders. In the early 1900s, outpatient treatment of alcohol problems also spread through Europe in such forms as municipal advice clinics (*Fürsorgestellen*) and temperance boards.

These early traditions of treatment were disrupted by many factors: two world wars and a depression; the advent of alcohol prohibition in some societies, and then its failure; the advent of global drug prohibition under the international narcotics treaties; and the conceptual separation of alcohol from drugs after 1920 (Courtwright, 2005). In many industrialized countries, the main institutions in which alcoholics could be found in the 1940s were mental hospitals, public hospitals and local jails (e.g. Corwin & Cunningham, 1944; Room, 1988). When specialized alcoholism treatment began again in the 1950s, initially it was primarily inpatient treatment with relatively long episodes of care. A separate system of drug addiction treatment agencies was often set up in parallel as drug problems emerged in one country after another. Particularly for drugs, treatment was often compulsory, under judicial civil commitment orders. Gradually over the last half-century there has been a trend towards the combination of treatment services and systems for alcohol and drugs (e.g. Weisner, 1992). For alcohol in many places, there was a trend until recently towards less compulsion in treatment, whereas strong coercion to treatment has remained common for drugs, as discussed below.

Since the 1980s, there has been a growth of "harm reduction" services, particularly for injecting drug users. The winning policy argument for these services, often against considerable moral opposition, emphasized the well-being of the population at large. Methadone maintenance became politically acceptable in the United States in the 1980s because it reduced crime rates. After the mid-1980s, harm reduction services for injecting drug users were implemented in many countries as a way of reducing the spread of HIV and other bloodborne infections in the population, and sometimes also to reduce public nuisance on the streets. Harm reduction services thus tend to be justified as providing benefits at the population level as well as assistance and care for those with drug use disorders.

The history and development of alcohol and drug treatment services have been described for a number of countries (Klingemann, Takala & Hunt, 1992; Klingemann & Hunt, 1998).

The general trend has been towards development of a range of specialized types of treatment and care. There are wide variations in the mix of types available between countries and often between areas within countries. On the other hand, in a globalizing world, there has also been considerable international diffusion of types of services and models of care, through the media of intergovernmental organizations such as WHO, professional societies, international nongovernmental organizations and the professional and scientific literature.

Almost universally, heavy alcohol and drug users are stigmatized (Room et al., 2001). Those who enter specialized alcohol or drug treatment are also often heavily socially marginalized and much less likely than the general population to be employed, stably housed, or in an intact family (e.g. Storbjörk & Room, 2008). Since the international drug control treaties require that nonmedical use of drugs be criminalized, essentially all countries have specific criminal laws concerning trafficking or other involvement in drug markets, and most also have criminal laws concerning the use of drugs. Many who are in treatment for drug use disorders are thus stigmatized as having criminal records, even if they are not entering treatment specifically because of a criminal court referral.

These tendencies in alcohol and drug treatment populations give a special character to policy and legislation for substance use disorders – which differ from the policy and legislation for most other disorders. There is a great deal of special legislation for the treatment and rehabilitation of those with substance use disorders; over one-half of the countries in the ATLAS survey report it. However, much of the legislation is concerned with provisions for compulsory treatment or for treatment in lieu of jail or other punishment (Porter et al., 1999). Nearly half of the countries included in the survey report legislation concerning compulsory treatment. Drug courts, a relatively new innovation in which a programme of treatment is managed by a judge, with the patient cooperating under threat of jail as an alternative, have spread from the United States to many other countries; 21% of the participating countries report the presence of drug courts. The unusual distribution of drug courts by income group of the country may indicate that drug courts are most likely to be instituted where the alternative punishment is severe. If one considers all types of programmes that divert clients away from the criminal justice system and into treatment, some such diversion is in place in a majority of the countries reporting.

The high degree of marginalization of many persons with alcohol or drug disorders means that many have a considerable need for government benefits such as disability payments or care. In about 40% of the countries in the survey, such benefits are available (roughly equally to persons with drug use disorders and persons with alcohol disorders). Reflecting general patterns of the availability of welfare support, the benefits are more likely to be available in richer countries than in poorer ones.

Entering specialized alcohol or drug treatment is itself often stigmatizing (Room, 2005); how to provide specialized treatment and yet avoid contributing to further stigma is a continuing challenge for the field. The stigma associated with heavy alcohol or drug use, and the degree of coercion often involved in entry into treatment, mean that these treatment populations have special needs for the protection of their human rights (Barrett et al., 2008), including confidentiality concerning their treatment.

Alcohol and drug problems are relevant to most of the major social handling institutions of modern societies: not only the health system, but also criminal justice, welfare and disability systems. Alcohol and drug problems thus show up in the caseloads of a broad range of health and human services (Weisner & Schmidt, 1995; Tam, Schmidt & Weisner,

1996). Specialized alcohol and drug treatment services often emerged in a situation of neglect of the problems in these major systems, and were frequently set up by charismatic individuals or by self-help and other nonprofessional groups. Treatment services set up in such circumstances have made a very substantial contribution to the provision of care in many countries. However, there have also been instances in which such services have led to damaging results (e.g. Ofshe, 1980). Given the degree of coercion in much of the treatment, there is also a special need for both high and ethical standards of care in both professional and nonprofessional services.

Alcohol and drug problems are much more widely spread in the population than the smaller streams of cases entering specialized alcohol and drug treatment services would indicate. However, the problems tend to be more diffuse and less severe in the wider population than in those entering the specialized services (Storbjörk & Room, 2008). Substantial efforts have been made in many countries to improve screening, assessment and brief interventions for alcohol and drug problems in primary health care and other service systems, although progress has been slow in institutionalizing these improvements (Roche & Freeman, 2004). Destigmatizing specialist alcohol and drug treatment, and providing help and counselling for socially integrated heavy users who are less severely affected, are urgent tasks in many places in a public health approach to alcohol and drug treatment policy.

5.2 Policy frameworks and special legislative provisions

(Figures 5.1–5.8)

Background

- Nominated focal points were asked about the presence and nature of national substance abuse policies in their countries.
- Focal points were asked about the availability of special legislation in their countries pertaining to treatment and rehabilitation of substance use disorders.
- More specifically, focal points were required to indicate the presence and nature of special legislation for the compulsory treatment of substance use disorders in their countries.
- Focal points were asked in addition whether government benefits such as disability pensions, subsidies for food or housing, or any other benefits would be provided to persons with alcohol and drug use disorders in their countries.

Salient findings

Substance abuse policies

- The majority of countries in the survey (68.0%) reported having a national substance abuse policy, with 100% of high-income countries reporting having such a policy.
- The highest proportion of countries reporting substance abuse policies was in the European Region (93.2%). The African Region (32.6%) reported the lowest proportion of countries with substance abuse policies.
- In Europe, 45.5% of countries reported having separate policies for alcohol and for drugs. Separate policies on alcohol only were reported from some countries in Africa (2.3%) and Europe (18.2%). The largest proportion of countries reporting separate policies for drugs were in the Eastern Mediterranean (21.0%), South-East Asia (20.0%) and Western Pacific (40.0%) regions.
- Country income level appears to have an effect on the availability of substance abuse policies. A lower proportion of substance abuse policies was reported from the low-income countries (38.1%) compared with countries from the lower middle-income (63.4%), higher middle-income (79.3%) and high-income groups (100%).

Special legislation for treatment and rehabilitation of substance use disorders

- The presence of special legislation for the treatment and rehabilitation of substance use disorders was reported by 55.2% of countries in the survey.
- The highest proportions of countries in the survey reporting special legislation for the treatment and rehabilitation of substance use disorders were in the European (75.0%) and Eastern Mediterranean (71.4%) regions. Across the regions, the lowest proportion of countries reporting special legislation for the treatment and rehabilitation of substance use disorders was in Africa (25.6%).

- The country income level affects the presence of special legislation for the treatment and rehabilitation of substance use disorders. A greater proportion of countries in the high-income group (82.9%) reported having special legislation for the treatment and rehabilitation of substance use disorders than countries in the higher middle-income (60.7%), lower middle-income (58.5%) and low-income (24.4%) groups.

Legislation for compulsory treatment of substance use disorders

- Special legislation for the compulsory treatment of substance use disorders was reported from 42.5% of countries in the survey, with 30% of countries reporting special legislation for the compulsory treatment of both alcohol and drug use disorders together.
- The Western Pacific Region reported having the highest proportion of countries (80.0%) with special legislation for the compulsory treatment of substance use disorders. In this region, 33.3% of countries reported having special legislation for the compulsory treatment of drug use disorders only.
- The lowest proportions of countries with special legislation for the compulsory treatment of substance use disorders were reported from Africa (16.3%) and the Americas (25.0%).
- There is no strong effect of country income on the presence of special legislation for the compulsory treatment of substance use disorders. Special legislation for the compulsory treatment of substance use disorders was reported from 60.0% of high-income countries, 44.8% of higher middle-income countries, 47.5% of lower middle-income countries and 21.4% of low-income countries.

Government benefits for substance use disorders






- Government benefits for people with alcohol and drug use disorders were reported from 40.6% of countries in the survey.
- The Western Pacific (78.6% for alcohol, 73.3% for drugs) and European (69.0% for alcohol, 70.5% for drugs) regions reported the highest proportions of countries providing government benefits for persons with alcohol and drug use disorders.
- No country in South-East Asia reported having government benefits for persons with alcohol and drug use disorders.
- There is a strong effect of country income on the provision of government benefits for substance use disorders, with over 80% of high-income countries in the survey and approximately 12% of low-income countries reporting the provision of government benefits for persons with alcohol and drug use disorders.

Notes and comments

- The question on substance abuse policies provides an interesting insight into the distinctions between the areas of mental health, drugs and alcohol in countries. One

predominant model is not seen, though the most commonly reported model has alcohol and drugs being considered together, but separately from mental health. It is not clear why many countries do not have any policies, nor is it clear what the impact is of having or not having such policies.

- Special legislation for the treatment of substance use disorders is in place in many countries. A review of such legislation was conducted by WHO in 1999 (Porter, 1999).
- Such legislation typically may be required for a number of purposes, namely: to regulate controlled substances that are used in the treatment of substance use disorders such as methadone, to facilitate the referral of people from the criminal justice system to the treatment system, to enable the compulsory treatment of substance use disorders, or to provide for the structure of the treatment system.
- It is noteworthy that the most common model is to include both alcohol and drugs together in such legislation.
- The compulsory treatment of substance use disorders is controversial but is nonetheless envisioned in the legislation of many countries. A recent WHO report describes the nature of compulsory treatment in a number of countries in the Western Pacific Region (WHO, 2009b).
- The data collected in this survey do not distinguish between the presence of legislation only for compulsory treatment and the widespread implementation of such legislation.

-  Separate policy for alcohol and separate policy for drugs
-  Separate policy for drugs only
-  Separate policy for alcohol only
-  Policy for alcohol and drugs together
-  Policy for mental health, alcohol and drugs together

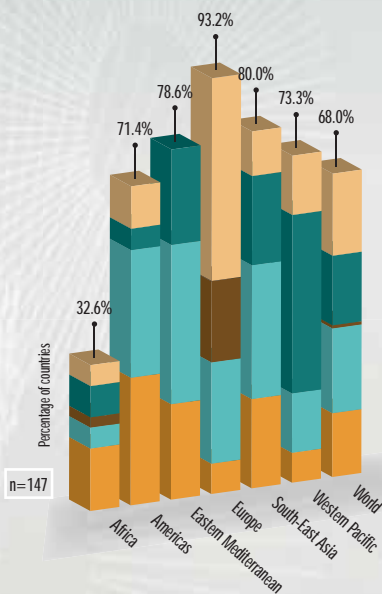


FIGURE 5.1
PRESENCE AND NATURE OF
SUBSTANCE ABUSE POLICIES,
BY REGION, 2008

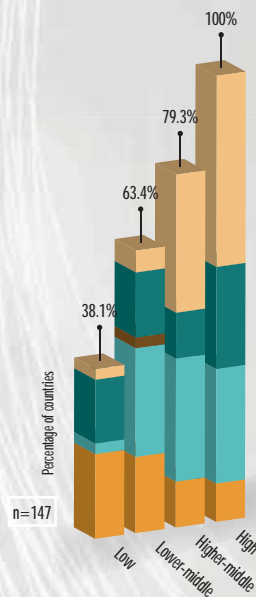


FIGURE 5.2
PRESENCE AND NATURE OF
SUBSTANCE ABUSE POLICIES,
BY INCOME GROUP, 2008

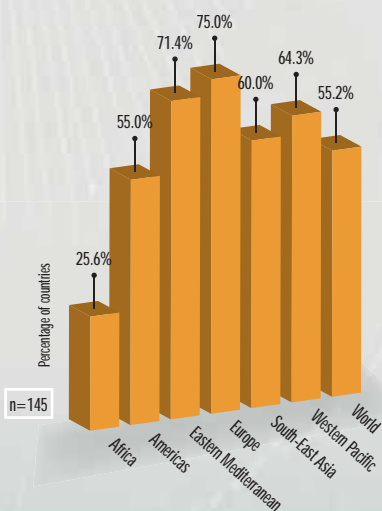


FIGURE 5.3
PRESENCE OF SPECIAL
LEGISLATION IN COUNTRIES
FOR THE TREATMENT AND
REHABILITATION OF SUBSTANCE
USE DISORDERS, BY REGION, 2008

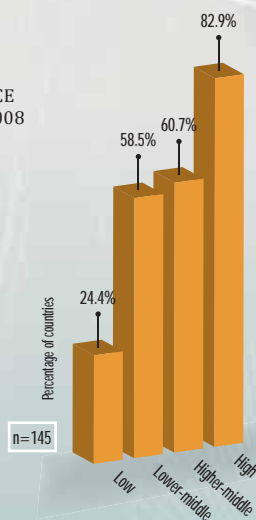


FIGURE 5.4
PRESENCE OF SPECIAL
LEGISLATION IN COUNTRIES
FOR THE TREATMENT
AND REHABILITATION OF
SUBSTANCE USE DISORDERS,
BY INCOME GROUP, 2008

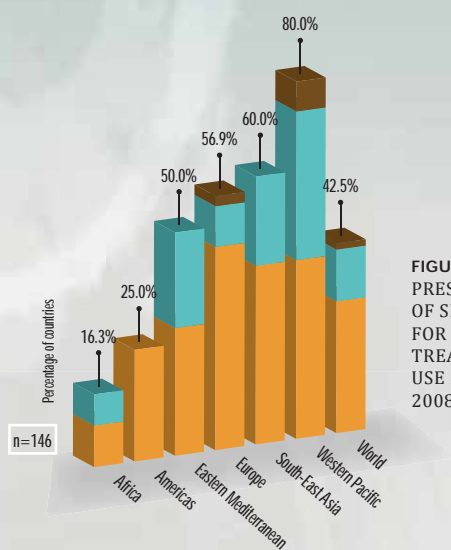
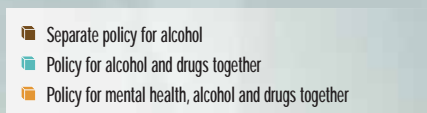


FIGURE 5.5
PRESENCE AND NATURE
OF SPECIAL LEGISLATION
FOR THE COMPULSORY
TREATMENT OF SUBSTANCE
USE DISORDERS, BY REGION,
2008

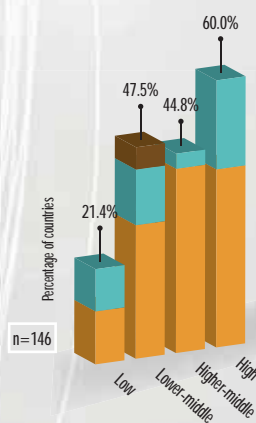


FIGURE 5.6
PRESENCE AND NATURE
OF SPECIAL LEGISLATION
FOR THE COMPULSORY
TREATMENT OF
SUBSTANCE USE DISORDERS,
BY INCOME GROUP, 2008

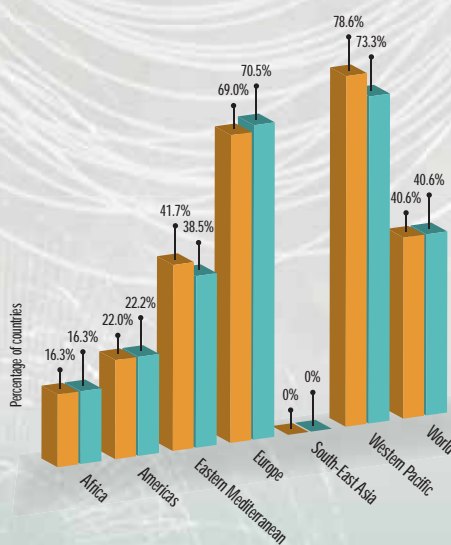
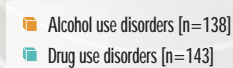


FIGURE 5.7
PROVISION OF
GOVERNMENT BENEFITS
FOR SUBSTANCE USE
DISORDERS, BY REGION,
2008

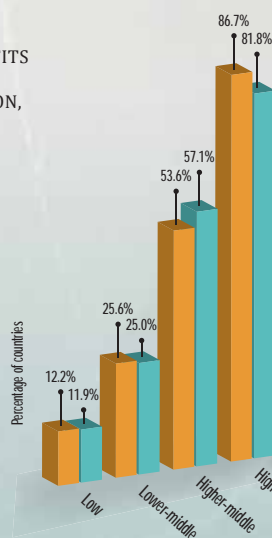


FIGURE 5.8
PROVISION OF
GOVERNMENT BENEFITS
FOR SUBSTANCE USE
DISORDERS, BY INCOME
GROUP, 2008

5.3 The criminal justice system and substance use disorders

(Figures 5.9–5.12)

Background

- Nominated focal points were asked to provide information about the presence of drug courts in their countries.
- Focal points in countries were requested to indicate whether there would be programmes in their countries referring or diverting clients from the criminal justice system towards treatment.

Salient findings

Drug courts

- The presence of drug courts was reported in 20.5% of countries.
- The highest proportion of countries with drug courts was in the Eastern Mediterranean Region (38.5%). The African (14.0%) and Americas (14.3%) regions had the lowest proportions of countries with drug courts.
- There was no effect of country income level on whether or not countries had drug courts.

Programmes diverting from the criminal justice system towards treatment

- Half of the countries in the survey (52.2%) reported having programmes referring or diverting clients from the criminal justice system towards treatment.
- The highest proportions of countries in the survey with programmes referring or diverting clients from the criminal justice system towards treatment were reported by Europe (66.6%), the Western Pacific (66.6%), the Eastern Mediterranean (61.6%) and South-East Asia (60.0%). Africa reported the lowest proportion of countries with these programmes (27.9%).
- For the majority of surveyed countries in the African, Americas and European regions, programmes referring or diverting clients from the criminal justice system towards treatment apply to both alcohol and drug use disorders. In the Eastern Mediterranean and South-East Asian regions, higher proportions of countries (38.5% and 40.0% respectively) reported having these programmes for drug use disorders only.
- There is an income effect on the presence of these programmes across different income groups of countries, with 84.9% of high-income countries in the survey and 38.1% of low-income countries reporting the presence of these programmes. The lower middle-income countries reported the highest proportion of programmes for drug use disorders only (24.4%).

Notes and comments

- Systems of referral from the criminal justice system to the treatment system are present in the majority of countries in the survey, and may warrant greater evaluation and discussion.
- The predominant model of inclusion of both alcohol and drugs in schemes that refer from the criminal justice system to the health care system suggests that in many cases the scheme is concerned not just with the crime of illicit drug use or possession but with crimes associated with both legal and illegal substance use.
- The reported data on presence of drug courts in countries should be interpreted with caution as the understanding of the term by nominated focal points could vary, and reported data could also reflect the presence of special procedures for offenders with drug use disorders.

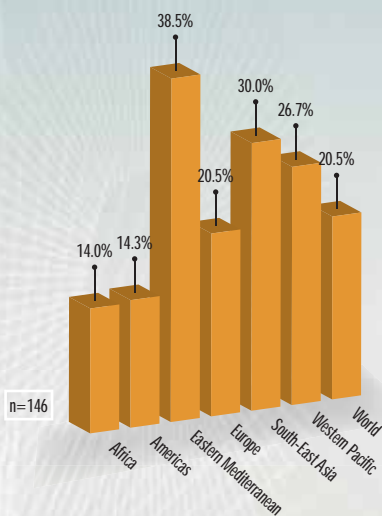


FIGURE 5.9
PROPORTION OF COUNTRIES
WITH DRUG COURTS, BY REGION,
2008

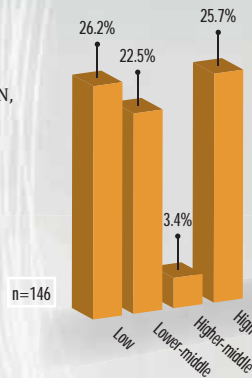


FIGURE 5.10
PROPORTION OF COUNTRIES
WITH DRUG COURTS, BY
INCOME GROUP, 2008

■ For both alcohol and drug use disorders
■ For drug use disorders only

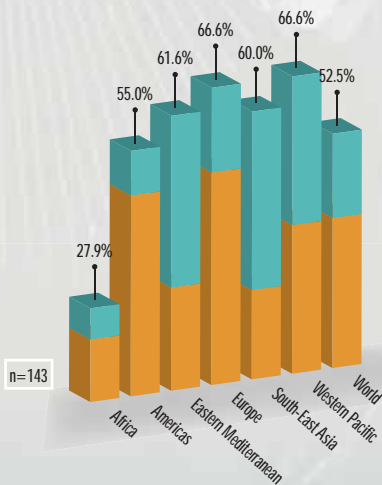


FIGURE 5.11
PROPORTION OF COUNTRIES
WITH PROGRAMMES
REFERRING OR DIVERTING
CLIENTS FROM THE
CRIMINAL JUSTICE SYSTEM
TOWARDS TREATMENT,
BY REGION, 2008

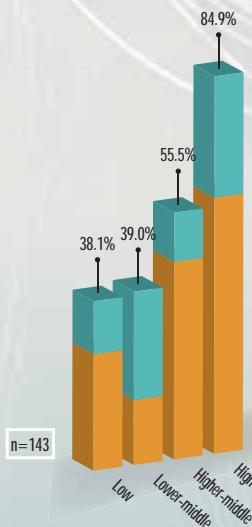


FIGURE 5.12
PROPORTION OF COUNTRIES
WITH PROGRAMMES
REFERRING OR DIVERTING
CLIENTS FROM THE
CRIMINAL JUSTICE SYSTEM
TOWARDS TREATMENT,
BY INCOME GROUP, 2008

