9 Compulsory Drug Treatment in Kazakhstan

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Introduction

Despite the success in implementing the evidence-based, multidisciplinary support approaches in drug addiction medicine, at best only one in six people who might benefit from drug dependence treatment has access to treatment programmes (WHO & UNODC, 2020). Among the range of factors that lead to this appalling statistic, one factor relates to the stigmatisation and criminalisation of those who are involved in drug use. As a result, the measures to treat drug users can include isolation, restriction, and coercion posed upon people with drug use disorders. Even though WHO and UNODC's international standards declare availability, access, attractiveness, and appropriateness as the main principles for the treatment of drug use disorders (WHO & UNODC, 2020), a number of current public health systems support the idea of varied forms of treatment programmes, with involuntary options for drug-addicted patients being one of the poles on such a spectrum (UNODC, 2022a).

According to Wild (1999), compulsory drug treatment can be defined as the mandatory enrolment of individuals, who are often but not necessarily drug-dependent, in a drug treatment programme. Proclaimed by public health politicians as a cost-effective alternative to criminal penalisation and palliative-oriented services for severe, terminal forms of addictions, for decades compulsory treatment programmes have provoked controversy all over the world in the context of ethical dilemmas and risks to human liberties (Werb *et al.*, 2016). In 2009, an international survey carried out in 109 countries discerned that 69% of state systems exercised compulsory treatment options in various forms, from flexible outpatient programmes to strictly structured and isolating inpatient communities (Israelsson & Gerdner, 2012).

Investigating the acceptance of compulsory treatment in Sweden, Palm & Stenius (2002) mentioned two types of motives underlying the persistence of coercion in drug treatment systems: utilitarian motives (compulsion to protect society) and paternalistic motives (compulsion to promote the well-being of the individual). Exploring the social basis for coercion

exertion in the current sphere of mental health, Szmuckler & Appelbaum (2009) suggested substituting it with the more ethically appropriate term 'treatment pressure'. The authors concluded that pressure, to different extents, has become more relevant in the social agenda over the last two decades. Sophisticated legal regulations and acts, especially in developed countries, tend to increase the integration of people with mental issues into communities. In the meantime, the community is provided with more opportunities and duties including those initiating pressure towards resisting patients. The authors defined the forms of treatment pressure as follows: persuasion, interpersonal leverage, inducement, threats, and compulsory treatment.

In terms of drug addiction treatment, the literature data present various definitions of the types of involuntary treatment where the extent of free choice limitation matters. According to Australian authorities in drug policy development, involuntary treatment is defined as a more restrictive type of mandatory approach, whereas milder forms of compulsory commitment to treatment are referred to as coerced programmes. Models of mandatory treatment can be split into five main categories: court-mandated treatment, drug courts, compulsory, prison-based treatment, civil commitment, and centre-based compulsory rehabilitation (Vuong et al., 2019). The wide variety of models and country contexts contributes to the discrepancies in the assessment of programmes providing services without the free will of patients. This entails contradictions and arguments in policymaking circles all around the world.

The experts in the field highlight the role of general political regimes and the degree of free will acknowledgement as the scope for the controlling, restrictive measures in addiction treatment systems. In this regard, it is of considerable interest to gain insights in post-Soviet territories, which inherited contradictory public health systems that were supposed to be totally community-oriented but made use of forced labour and severe stigmatisation of people with addictions (Lunze et al., 2016). Sharing this common experience with other post-Soviet countries, the case of Kazakhstan's compulsory treatment is useful as an example of the transitional reforms in drug addiction treatment systems, whereby the involuntary sector partly stagnates due to a combination of factors, whilst, at the same time, keeping its contradictory yet stable positions alongside humanisation processes in other law enforcement fields (Chubaeva, 2021).

1. Methodology

Despite the proliferation of various prevention, treatment, and harm reduction approaches addressing drug addictions, the ethical issues of freedom limitations for drug-using patients continue to be on agendas all across the globe, regardless of country incomes and budgets invested into the field. To what extent could the treatment systems, on behalf of the public and state, exercise coercion and impose mandatory requirements in order to reduce attrition rate, increase treatment compliance, and ensure safety in communities? How could the balance between the community and patient well-being be achieved, putting into practice the public mandate of compulsory drug treatment measures? What are the arguments and legal basis to support the status quo for constraining approaches with disputable effectiveness? What interventions are available or, in contrast, underrepresented in compulsory sectors, compared to voluntary drug treatment?

Addressing these questions, this chapter describes the case of compulsory treatment in Kazakhstan as a representative example of the Soviet inheritance of restrictive and isolating treatment approaches for people with severe addictions. It yields insights about the organisational structure, legal regulations, and services in the compulsory sector, which takes a similar key place to the voluntary sector in the state drug treatment system.

In Kazakhstan, only compulsory forms of involuntary treatment are established. A legal basis for coercive programmes does not exist. In other words, in Kazakhstan there is not a court procedure, if the involuntary treatment can be offered to a drug-using convict as a more merciful alternative to a prison sentence. Therefore, in all of the further analysis in this chapter, the terms 'compulsory', 'mandatory', and 'involuntary' will be used as synonyms.

In carrying out the research, a combination of two methodological approaches was employed. In the first step, desk research was conducted to identify all of the officially available information on compulsory drug treatment in Kazakhstan. Additionally, the internally used compendiums, annual statistical reports, and short communications were analysed. In the second step, a series of three expert interviews was carried out. All the experts have at least five years' experience in the organisation or provision of compulsory treatment in two regional clinics in Kazakhstan (Pavlodar and Semey) and gave their feedback on the working routine, regiments, and social characteristics of treated patients.

Expert #1, male, 40 years old, a psychiatrist, has five years' experience of working in the compulsory treatment department in Pavlodar city and has the same amount of experience as a doctor in charge of that department. The department provides treatment for addicted patients from the whole Pavlodar region (with a population size of 750,000). The compulsory department is a division of the central drug addiction hospital and includes 60 beds for male patients with four doctor positions and ten nurses.

Expert #2, female, 65 years old, a psychiatrist, has ten years' experience of working in the compulsory treatment department in Semey city. The department provides treatment for addicted patients from Semey city and its suburban areas (with a population size of 300,000). Like expert #2, her department is a division of the central drug addiction hospital and includes 80 beds for male patients with five doctor positions and ten nurses.

Expert #3, female, 55 years old, a chief analyst at the epidemiology and drug policy department of the Republican Scientific and Practical Centre of Mental Health (Pavlodar city) (with 10 years' experience). Her expertise covers the processing of data with regards to compulsory treatment departments nationwide.

For all the experts, a semi-structured interview was carried out (40–60 minutes). All the records were transcribed verbatim and analysed according to thematic coding in correspondence with the chapter sections. Some of the expert explanations that clearly clarify or exemplify the researched topic are quoted in excerpts throughout the chapter. Internally operational materials and statistical data provided by Expert #3 have also been used in the analysis, in addition to officially published information.

2. *Legal Regulations*

Kazakhstan's compulsory treatment system was inherited from the Soviet narcological structure, first introduced in the form of medical and labour dispensaries ('*profilactoriums*') on 8 April 1967. The main principles and aims of compulsory treatment were established more than 55 years ago and have not changed radically since then (Grishko & Derenova, 2022).

The subject of compulsory treatment has been on the policy agenda of public health managers for the last decades, during which time experts have questioned the effectiveness and principles of the treatment in the medical setting with social restrictions of different extents (Kozhakhmetov,

2019). Kazakhstan's legal standards stipulate two forms of compulsory treatment: within the penitentiary system alongside criminal punishment (which was described in the previous chapter) and in community clinics under the Ministry of Public Health as a form of sanction against misdemeanours, offences, and severe addictions. The main principles and rules of compulsory treatment were established at the highest legal level (after the constitutional level) of the Code of the Republic of Kazakhstan: On public health and healthcare system (2020). Before that, compulsory treatment procedures were regulated by the Law of the Republic of Kazakhstan: On compulsory treatment of patients with alcoholism, drug addiction, and substance abuse No. 2184 (1995). The current standards are listed in Articles 171–174 of the Code and include (i) descriptions of the basic rights, social guarantees, and duties of patients during compulsory treatment, (ii) the motives for and procedures of pre-court preparations of compulsory treatment cases, (iii) the regime and safety requirements, and (iv) discharge steps.

Additionally, the articles include references to a range of operational acts and algorithms that elucidate the structure, organisation, and rules for the medical departments and clinics in the provision of compulsory services. As of September 2022, there were two acts that describe inner order rules for compulsory treatment facilities and the basic anti-relapse services rendered to patients upon release (Ministry of Healthcare of the Republic of Kazakhstan, 2020a; Ministry of Healthcare of the Republic of Kazakhstan, 2020d).

According to the state standards, compulsory treatment within the community drug treatment setting is sentenced in case of antisocial behaviour extreme microsocial maladaptation, and fierce resistance to voluntary treatment. Plaintiffs in a lawsuit in these cases could be family members, labour collectives, public organisations, internal affairs bodies, prosecutor's offices, or child protection authorities. The court's decision, based absolutely on two factors (the degree of patient compliance and addiction severity), can result in various treatment sentences, ranging from six months to two years (or three years for repeat cases) (Eremenko, 2006).

According to the state standards, referral to specialised medical institutions is not applicable to the following persons: severely disabled people with mental and somatic diseases, pregnant women or women with children under the age of eight, minors, males over 60, and females over 55.

Considering the critical role of isolation and security in the provision of the compulsory treatment regimen, the legal documents establish different modes of surveillance for patients. Most patients are placed under *general* surveillance, which guarantees their free movements within compulsory

departments and outside (with a time limit). If a patient does not comply with the daily routine and violates the freedoms of other patients or medical staff, he/she is placed under *intense* surveillance, which means that leaving the department is strictly prohibited. Some of the patients requiring assistance due to mental and somatic issues are put under strict surveillance on a special ward to minimise risks for their health. The most restrictive surveillance is imposed for patients who violate the treatment rules and threaten the life and health of others. For these extreme cases, every compulsory department has a confinement ward with a round-the clock security officer. The rooms on this ward resemble prison cells, with a bed, table, and toilet zone. During the confinement period, a patient is not allowed to leave the ward. Being moved to a special ward can only be imposed as an ultimate sanction by the head doctor of a clinic, who must report to a controlling prosecutor and ensure the period does not exceed ten days.

During the course of compulsory treatment, patients are guaranteed to be able to receive and send parcels, money, and postal orders, and subscribe to periodicals; to be employed in accordance with the labour legislation of the Republic of Kazakhstan; to purchase – using funds held on a personal account – food and essentials, as well as other items (board games, musical instruments, hygiene products, etc.) that are not prohibited for storage and use in the department; to meet with close relatives and their spouse (wife); and to take daily walks in accordance with the daily observational plan, accompanied by a medical worker and an employee of the security organisation.

A person with a mental or behavioural disorder (disease) associated with the use of psychoactive substances can only stop compulsory treatment and be discharged from an organisation providing mental health care by a court order in the following cases: following the expiration of the determined period of compulsory treatment; upon the identification of concomitant serious diseases; and ahead of schedule due to successful treatment, but not more than six months early.

Despite these detailed descriptions of release options, the current standards do not describe the indicators of compulsory treatment success, which are concluded only based on a discretionary decision by the responsible doctors. From a practical perspective, patients have to adhere to the minimum treatment requirements mentioned in the standards: 1) to comply with the internal regulations; 2) to fulfil the official requirements of the administration and medical personnel; 3) to undergo the prescribed treatment; 4) to participate in cultural, leisure, and sports events and socially useful work, taking into account medical recommendations; 5)

to take care of the clinic's property; 6) to maintain cleanliness and order in the department, as well as take their turn in cleaning the area for a maximum of two hours a week; 7) to maintain personal hygiene.

In the event that a patient breaches the rules, the clinic's administration is permitted to apply to the court for a one-year extension to the term of the treatment.

The working conditions of persons with drug use disorders in compulsory treatment clinics are determined by the general labour legislation of the Republic of Kazakhstan, and there are neither special qualifications regarding the condition of being in a restricted area nor any rules regarding additional payments or salary guarantees.

During the period of release preparation, the administration of the organisation providing the compulsory treatment has to inform the local executive body at the patient's place of residence about their release from the medical organisation to assist in accommodation and labour arrangements and to organise further medical surveillance and voluntary anti-relapse treatment. To fulfil the latter requirement, patients have to register at local treatment centres for dispensary surveillance programmes upon release. If they evade registration and supportive treatment, a person may be subjected to forcible transfer by the internal affairs bodies. This can be considered an extra restrictive measure in treatment services that is supposed to ensure compliance and provide continuity in medical support for resistant individuals with a history substance abuse. On the other hand, this action is imposed without a court statement and provided directly by collaborating doctors and police officers.

The legal standards that regulate the anti-relapse and support treatment upon release from compulsory treatment were firstly introduced in parallel to the Code of the Republic of Kazakhstan: On public health and healthcare system (2020) in November 2020 and there were no earlier versions (Ministry of Healthcare of the Republic of Kazakhstan, 2020c). These standards list the minimum basic requirements for supportive treatment interventions in the form of an individual treatment plan that includes various interventions. Diagnostic methods include biological drug tests for drugs, an HIV test, psychometric tests, a quality of life and social functioning assessment, and laboratory and neurophysiological tests. Pharmacotherapy covers the prescription of psychopharmacotherapy, symptomatic therapy, therapy for comorbid somatic and mental pathology, and antagonistic therapy using opioid receptor blockers. Psycho-social support should include medical, psychological, and social counselling for patients and their families, and individual and group psychotherapy sessions.

In their form, all of these basic requirements meet the principles of recovery management, which emphasises the importance of the chronic disease paradigm and underlines the unprecedented role of long-term comprehensive supportive programmes (Scott et al., 2007). Meanwhile, the current standards do not include community-based support resources and services focusing only on outpatient clinical capacities. Furthermore, they lack such evidence-based approaches as recovery communities (e.g. twelve-step peer support), recovery education and coaching, harm reduction trainings, and intoxication first aid trainings. Environmental interventions aimed at reducing substance use and criminal behaviour are also beyond the scope of the current standards for post-compulsory management. According to World Health Organization & United Nations Office on Drugs and Crime (2020), it is necessary to involve the whole system, integrating all treatment modalities and the participation of all stakeholders outside the health sector to provide effective recovery management. Multiple stakeholders in communities play a key role and should be engaged in the recovery process. These include families and caregivers, friends, neighbours, mutual self-help groups, spiritual and community leaders, stakeholders from the educational sector, the criminal justice system, and sports and recreational facilities.

3. Organisational Structure and Statistical Data

Despite the obvious drawbacks and disputable effectiveness of compulsory programmes declared by a wide array of studies, involuntary treatment remains prevalent in Kazakhstan's public health system. According to the official statistical data, the proportion of compulsory treatment within the whole drug treatment sector amounted to 13% of all drug treatment in 2020 (Figure 1).

As the graph depicts, from 2018 the rate of compulsory treated patients has been on the rise, which could be attributed to various factors. One of them is the substantial increase in the total number of drug-addicted inpatients, alongside the reduction in the total bed capacity of public clinics (e.g. 4,029 beds in 2019, compared to 3,938 in 2020). Thus, this increase is more likely to be relative because the absolute number of cases experienced a slight decrease, like in the voluntary sphere (e.g. 3,813 patients in 2019, compared to 2,814 patients in 2020). The proportion of compulsory hospitalisation cases is characterised by the disparity at the local level. In 2020, the compulsory treatment proportion was extremely

high in the Kostanay (63.5%), Pavlodar (31.1%), and West Kazakhstan (31.0%) regions (Expert #3, 2022).

Compared to 2020, the number of beds for compulsory treatment in 2021 decreased by 170 and totalled 1,894 beds. The absolute number of beds for compulsory treatment has decreased in the Akmola, Almaty, West Kazakhstan, Kyzylorda, and Turkestan regions.

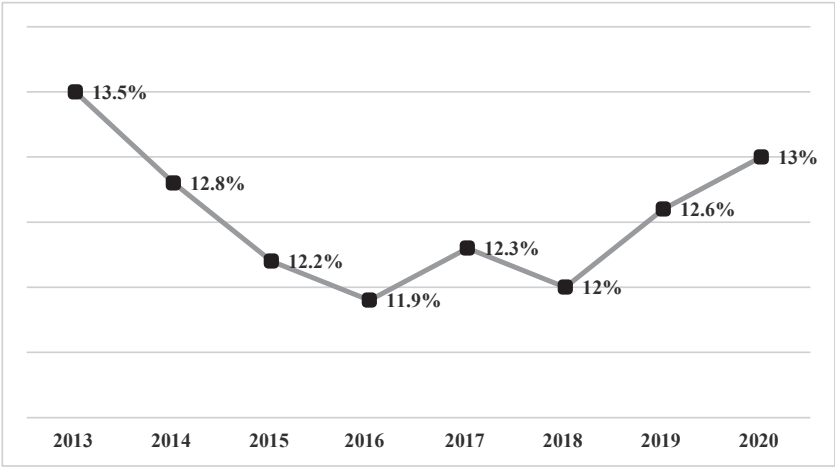

Figure 1: Compulsory Drug Treatment Cases in the Public Health System, 2013–2020

The excessive prevalence of compulsory treatment within the public health system is reflected in the large percentage of bed capacity allocated to involuntary services. In 2020, compulsory beds accounted for 55.4% of all drug treatments, with just a slight reduction from 2,067 beds in 2019 to 2,064 in 2020. Local public health offices all across Kazakhstan tend to reduce the number of beds at the expense of hospitalisation opportunities in the voluntary treatment sector, while maintaining the apparent predominance of compulsory treatment facilities in all regions (with the exception of Astana city and the Kyzylorda region). In contrast, beds for psychosocial interventions comprised no more than 9.5% as of 2020 (Figure 2), with this form of treatment being absent in the Pavlodar, Mangystau, and North Kazakhstan regions (Republican Scientific and Practical Mental Health Centre, 2021). In parallel with the rise of compulsory treatment beds, there is a steady decrease of beds for psychosocial interventions provided for voluntary treatment in public hospitals.

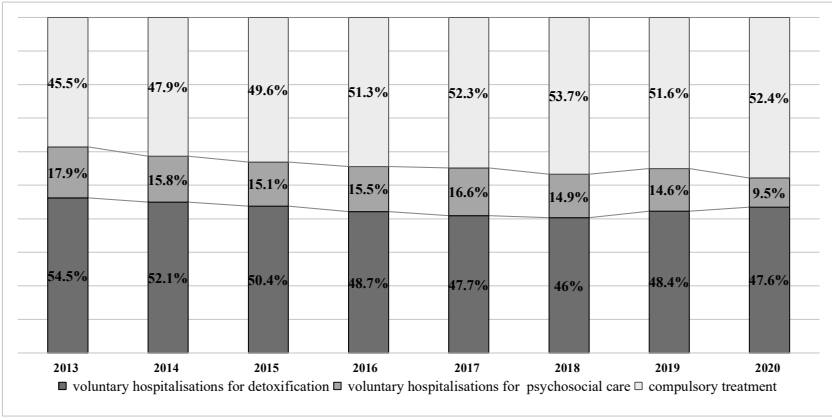

Figure 2: Structure of Public Beds for Hospitalisations Due to Substance Addictions

In contrast with the increased bed capacities of the compulsory sector, the proportion of budgets allocated to involuntary programmes remain low. For instance, in 2016 and 2017, the proportion of the treatment budget for compulsory patients accounted for only 31.2% and 31.9% respectively (Expert #3, 2022). It should be added that all compulsory treatment programmes are financed by the state and excluded from private funding. With the introduction of the health insurance model to the national public health system in 2017, various options for chemical addiction treatment (including compulsory) were introduced and have since been covered by the guaranteed finance package, with free provision for all citizen across all regions of Kazakhstan (Gulis et al., 2021; University Medical Center, 2022).

Drug addiction treatment costs are calculated using operational algorithms that include a special formula and a coefficient that depends on the number of patients officially registered by local clinics (Ministry of Healthcare of the Republic of Kazakhstan, 2020b). In turn, local administrations are entitled to allocate the budget to various options (from primary prevention to recovery services). In general, in 2019 the proportion of addiction treatment costs accounted for 7.61% of the total sum of the free guaranteed package (886,238,610 tenge) (Expert#3, 2022). The current data on the republican budgets for compulsory treatment have, to the best of our knowledge, not yet been published.

As of 2021, the medical staff coverage in compulsory treatment departments was sufficient and amounted to 95% of the required number of doctors (Table 1).

Table 1: Compulsory Treatment Staffing in 2021 (Doctors)

Regions	Percentage of occupation of planned positions	Real number of doctors
Akmola	11.75	6
Aktobe	4.0	4
Almaty	2.5	3
Atyrau	2.0	2
West Kazakhstan	10.0	7
Zhambyl	4.25	4
Karaganda	6.5	6
Kostanay	9.0	4
Kyzylorda	2.0	2
Mangystau	1.5	1
Pavlodar	6.75	4
North Kazakhstan	0.5	0
Turkestan	2.5	2
East Kazakhstan	15.25	14
Nur-Sultan	2.5	2
Almaty	11.0	10
Shymkent	3.0	3
Kazakhstan	**95.0**	**74**

With regard to clinical diagnoses, Kazakhstan's compulsory system has provided treatment services predominantly to patients with alcohol use disorders (Figure 3) over the span of about ten years. This tendency is consistent with the voluntary treatment sector, where alcohol use disorders prevail in patients of both genders and in all regions of the country. Polysubstance addictions take second place in the diagnosis structure of compulsory treated addictions (Republican Scientific and Practical Mental Health Centre, 2021).

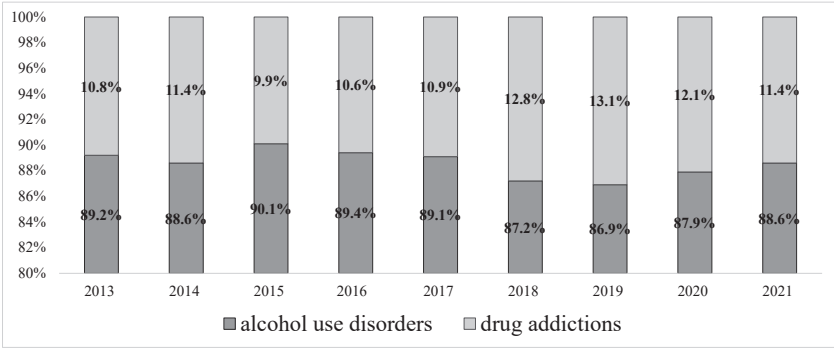

Figure 3: The Structure of Diagnoses Registered in the Compulsory Treatment Sector

In terms of organisational structure and subordination, the reform in the public mental health sector resulted in a reduction in the number of independent medical organisations that provide exclusively compulsory drug treatment services after merging with regional mental health centres. For example, there were six medical organisations for compulsory treatment with 850 beds in 2013 versus one medical organisation with 102 beds in 2020. As of 2022, compulsory treatment is provided only in departments under the jurisdiction of 17 local mental health centres. The aim of this merging is to unify and standardise business processes as well as to ensure consistency in treatment services from the unified providers in each region of Kazakhstan.

According to the public health economics approaches, the cost-benefit characteristics of medical hospitals are measured by the period during which clinical beds remain occupied and medical services can be utilised respectively per year. Ideally, from a public health management perspective, a bed is expected to 'function' 365 days a year. As for the compulsory treatment sector, the average number of bed occupation days was 310 per year in 2021, an increase of 11 days compared to 2020 (299.4 days). However, the mean indicator has unequal distribution in different regions. In some territories, compulsory beds tend to remain vacant for too long and become unprofitable. In these cases, the directors of clinics where compulsory beds are underutilised have to contemplate reprofiling them in favour of departments specialising in psychosocial support. This practical tendency closely corresponds with the operational goals of the Ministry of Health, which specifies capacity building in psychosocial rehabilitation for mental disorders to be the top priority in the field (Ministry of Health-

care of the Republic of Kazakhstan, 2019). Meanwhile, according to the aforementioned statistical data on the stable number of compulsory beds (Figure 2), the reprofiling process has been going much more slowly than planned. One of the reasons for this, according to experts, is the COVID-19 pandemic, which stagnated the reforms compared to the previous two years (Expert #3, 2022).

Among the other indicators of compulsory treatment effectiveness, which are officially registered by state statistical systems, are those that reflect the number of escapes from treatment facilities (Figure 4) and the rate of compulsory rehospitalisations. The latter is directly associated with the quality of post-treatment remissions (Expert #3, 2022).

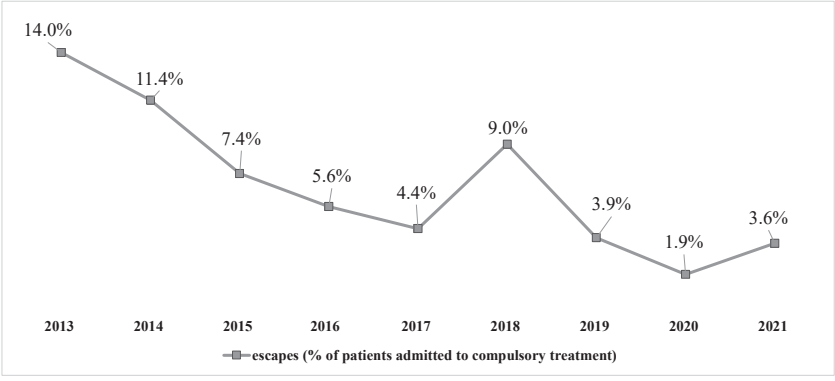

Figure 4: Number of Escapes from Compulsory Drug Clinics, 2013–2021

Attempts to escape from compulsory clinics can be equated with dropouts in the voluntary sector. Brorson et al. (2013) proved the association between the failure to complete voluntary treatment and a range of unfavourable effects: elevated risks for relapse, legal and health problems, and readmissions to the addiction treatment. A similar tendency was revealed for patients sentenced to compulsory clinics. In their study, Padyab et al. (2015), analysing more than 4,000 compulsory treatment cases with a significantly high rate of dropouts (59%), substantiated the association between noncompletion and an elevated mortality risk (16% increase), especially for men with a history of criminal behaviour. It should be noted that this strong association between treatment noncompletion and further social and health risks relates to compulsory treatment with psychosocial care (in Sweden) and might be different for mandating systems without supportive services, as is the case in Kazakhstan. Unfortunately, the data

testing this association in the context of Kazakhstan's compulsory system are not available yet. Meanwhile, every escape from compulsory facilities entails additional costs for the return of fugitives by means of police force involvement, prolonged terms of courses of treatment, and the increased likelihood of patient readmissions with a higher degree of resistance and non-compliant behaviour.

As regards the frequency of compulsory rehospitalisation in Kazakhstan, it was observed that almost every second patient admitted to compulsory treatment did not display any positive effects (e.g. remission) from a previous treatment episode. For example, 3,813 patients were admitted in 2019, of which 48.0% were rehospitalised in the same year, in 2020 the rate of readmittance was 60.8%, and in 2021 it was 46.3% (Expert#3, 2022).

The regional structure of readmittance cases varied significantly, from 1.8% (in Astana city) to 100% (in Almaty city) (Table 2). This observation can be explained by discrepancies in the hospitalisation approaches between regions. Doubtless, the regions with a high rehospitalisation rate provide a lower quality of service. On the other hand, the regions where rehospitalisations are strikingly low might impose controlling measures to prevent frequent rehospitalisations or experience too high a demand on services for new patients. For example, this is relevant for Astana city, which has seen rapid population growth due to internal migration processes.

Table 2: Regional Structure of Compulsory Rehospitalisation Cases

Region	Rehospitalisation Rate (%)		
	2019	2020	2021
Akmola	47.0	42.2	25.9
Aktobe	43.7	48.2	55.7
Almaty	84.3	70.2	70.2
Atyrau	1.7	25.6	0.0
West Kazakhstan	32.2	63.1	47.6
Zhambyl	89.7	75.9	92.7
Karaganda	11.5	35.4	7.6
Kostanay	33.3	53.0	38.3
Kyzylorda	61.5	69.5	90.1
Mangystau	20.3	42.9	35.3

Region	Rehospitalisation Rate (%)		
	2019	2020	2021
Pavlodar	48.5	48.3	52.3
North Kazakhstan	50.9	78.6	40.1
Turkestan	35.2	84.6	92.7
East Kazakhstan	36.9	30.3	20.8
Nur-Sultan	21.1	1.1	1.8
Almaty	87.9	100	100
Shymkent	64.4	86.5	55
Kazakhstan	**48.0**	**60.8**	**46.3**

The latest data available from official statistics that assess the prevalence of at least one-year remissions following compulsory treatment clearly question the effectiveness of these drug treatment services (Republican Scientific and Practical Mental Health Centre, 2021). As of 2017, the rate of one-year remissions was less than 4% (Figure 5).

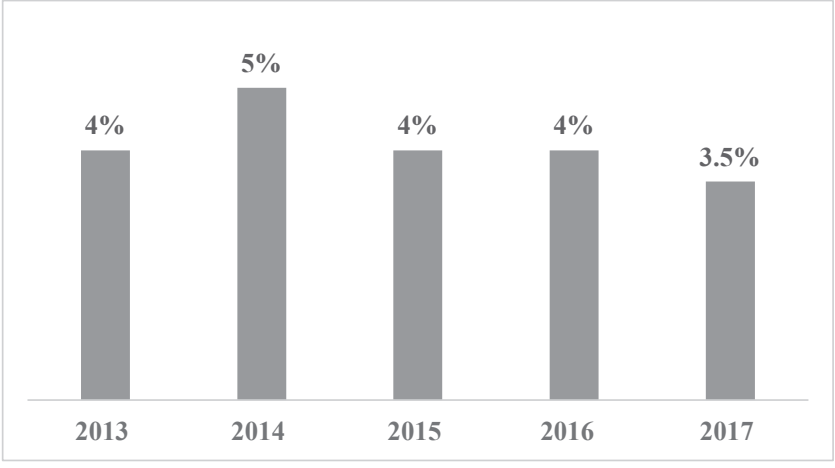

Figure 5: One-Year Remission Rate for Patients on Compulsory Courses of Treatment

The number of incidents (such as physical aggression, riots, or protests) was also high in 2017 (21.9% of the total number of involuntarily hospitalised patients was involved in such an incident) (Expert #3, 2022). In line

with the given statistical data, the annual reports from the ombudsman office have systematically registered cases of active destructive resistance to the treatment rules and regime requirements that entail stricter surveillance of non-compliant patients with temporary restrictions of their rights and social guarantees. Additionally, the human rights defenders underlined the lack of psychosocial rehabilitation interventions within compulsory treatment programmes and consider this finding to be the common key obstacle in violence de-escalation and therapeutic compliance facilitation (Human Rights Commissioner in the Republic of Kazakhstan, 2022).

4. Social Characteristics of Compulsory Treatment Patients and Services

Information on the demographic and social profiles of patients undergoing compulsory treatment in Kazakhstan are sparse and often contradictory. The media companies exploit images of marginalised alcohol and drug users who have been neglected by their relatives and 'imprisoned' in the treatment facilities 'as a punishment for an immoral lifestyle'. Mostly, these mass-media publications underline the social pertinence of restrictive measures to maintain public order and highlight the importance of police officers placing patients in clinics at the right time (Diapazon, 2018; Khabar24, 2021). This agenda encourages the stigmatisation of addicted people and prone to consider addictions through the penalisation prism. On the other hand, some media reports reflect criticism of compulsory approaches, exploiting a popular slogan about the absolute ineffectiveness of coercion with addicted patients (Sputnik Kazakhstan, 2018; KazTAG, 2020). In their eagerness to promote their specific angle, neither media approach properly substantiates their message with accurate and reliable statistical data and research results. Furthermore, accurate, peer-reviewed data and research projects are available only for patients who receive drug addiction services on a voluntary basis in Kazakhstan. To the best of our knowledge, there are only sporadic papers and references in local journals yielding brief insights into the compulsory population characteristics and services provided in clinics.

According to the assessment undertaken in the Karaganda compulsory clinic (situated in Central Kazakhstan) by Turtbayev et al. (2009) between 2006 and 2008, the most prevalent diagnosis was alcoholism, which matched the republican trend. However, the proportion of patients with drug addictions was also sizeable. In 2006, the percentage was 25%, in 2007 it was 24.5%, and in 2008 it was 22%. Persons aged 31 to 40 years prevailed among other age groups. Most of the assessed patients

had completed secondary education. According to Turtbayev, residents of urban areas had more chance of being referred to compulsory treatment. The authors attributed this finding to the active work of police officers in cities and towns and their availability to proceed such legal cases in courts, in collaboration with doctors. In rural areas, drug and alcohol addictions were more stigmatised and, as a consequence, more frequently hidden from the community services by relatives. Another explanation was related to lower levels of trust in police officers in villages where inhabitants 'do not want problems with police'. A large proportion of the patients identified themselves as belonging to the Russian ethnical group, which corresponds with the data retrieved from voluntary treated patients (Rossinskiy, 2006).

In social terms, the majority of patients that took part in the Karaganda assessment (up to 86%) were unemployed and did not have supportive family connections (up to 84%), which deteriorated their maladaptation and reduced the likelihood of them reintegrating into communities after completing the compulsory course of treatment (Turtbayev et al., 2009). Meanwhile, the modalities and social services provided to the patients were not described in the Karaganda assessment. Among the interventions practised in state clinics, Eskalieva et al. (2009) listed only psychopharmacological therapy, which was aimed at the reduction of resistant behaviour, the alleviation of depressive symptoms, and the controlling of cravings. This published information corresponds with the feedback from the expert who worked in Pavlodar compulsory clinic and confirmed that the principal focus over the whole course of treatment was on psychopharmacological therapy.

> The main principle for therapy in our department was medicine prescription. Our patients had to receive psychopharmacological treatment every day, regardless of the duration of their terms. That was normal practice, to receive tablets for six plus months in a non-stop fashion (Pavlodar expert).

The psychopharmacological treatment prescribed to patients does not differ from that used in voluntary programmes. In practice, patients received medications to treat withdrawal, depressive symptoms, dysphoria, and cravings (Eskalieva et al., 2009). Besides the correction of mental symptoms and comorbidities, the patients in the Karaganda compulsory clinic visited various kinds of medical specialist, although physician consultations were most prevalent (four consultations per patient). The patients had the opportunity to attend neurologist and dermatologist consultations (once a year per patient). Dental care was also available for the patients (up

to 30%). As a result of these consultations, in half of the cases, various somatic diseases were diagnosed (Turtbayev et al., 2009). The authors necessitated the reduction of compulsory treatment terms for addicted patients and mentioned the risk of patients losing their motivation for sobriety while being clinically imprisoned. The authors exemplified the experience of preterm releases from the Karaganda clinics (Figure 6).

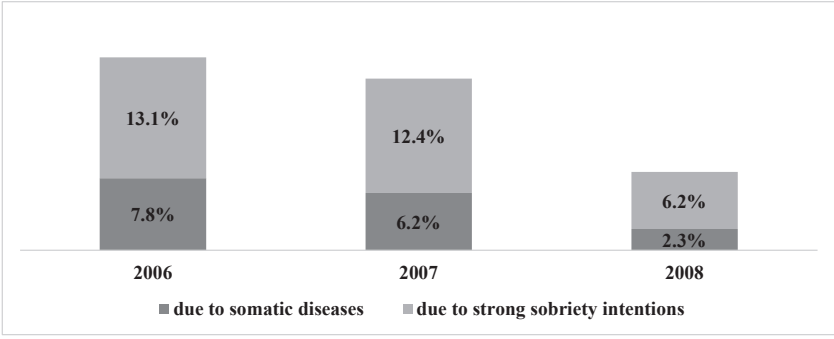

Figure 6: Preterm Releases from the Compulsory Treatment Clinic in Karaganda (based on the Data of Turbaev T.A., 2009)

A substantial proportion of preterm releases were considered by the authors to be successful cases of compulsory treatment, which they demonstrated to promote ideas about introducing a flexible duration of compulsory treatment in contrast to the existing punishment-oriented treatment model. Contrary to the Karaganda experience, the Pavlodar compulsory courses of treatment were more fixed in duration and patients had fewer chances to be released early due to successful recovery.

> At our compulsory department, all patients knew that the chance of being released earlier was minimal. That issue was determined only by responsible judges that required very good reasons for preterm termination. That was especially relevant for those who were in clinic less than six months (Pavlodar expert).

Countrywide, the average duration of compulsory treatment has been decreasing over time. For instance, it amounted to 183.7 days in 2021, having slightly declined in comparison to 2020 (192.9 days). From this mean value, it is obvious that preterm releases (less than six months) are rare practice in the sector (Expert#3, 2022).

In parallel, it is of great importance to understand not only for how many days patients are exposed to the treatment, but also to analyse to what extent compulsory-treated addicts have access to basic psychosocial help. Abundant evidence supports the idea of the importance of psychosocial interventions for drug use treatment. The voluntary basis for these services is a key element for their effective implementation and utilisation, even when provided for detained persons.

A number of studies show the effectiveness of psychosocial support in prisoners with mental issues and drug addictions (United Nations Office on Drugs and Crime, 2022b). In a systematic review of 21 studies, Thekkumkara et al. (2022) revealed the positive impact of various psychotherapy and counselling modalities (motivational intervention, interpersonal therapy, cognitive behavioural therapy, positive psychology intervention, music therapy, and acceptance and commitment therapy) on depression, anxiety symptoms, and addiction symptoms.

Meanwhile, the existence of the compulsory approach raises additional questions about the relevance and feasibility of acknowledged and standardised interventions in without-consent treatment regimens imposed on non-compliant persons barely meeting international recommendations and standards while increasing risks of human right violations. This goes in parallel with significant challenges caused by political factors and centralised systems of programme coordination in these countries (Vuong et al., 2017).

Meanwhile, provision of psychosocial support in the compulsory context could be also found in high-income countries. For instance, the US, New Zealand, and Swedish government acts establish compulsory treatment programmes with the obligatory inclusion of cognitive behavioural therapy (CBT) with family counselling, and peer and occupational therapy support for those with severe addictions, socially destructive behaviour, and voluntary treatment denial (Hazelden Betty Ford Foundation, 2017; New Zealand Ministry of Justice, 2020; Ledberg & Reitan, 2022; Palm & Stenius, 2002). Even advanced compulsory programmes that include psychosocial support fail to achieve results comparable with those gained in voluntary settings.

The data of Ledberg & Reitan (2022) draw attention to the elevated mortality risk immediately after discharge from Swedish compulsory treatment programmes that, in contrast to those in Kazakhstan, only last up to six months. Over this shorter period, Swedish patients struggle to maintain social relationships and suffer from feelings of isolation, depression, and anxiety. In their study, Petterson et al. (2021) postulated the lack of attention to patient inter-personal connections within detention institutions

and the negative effects of strict regimes on the social functioning of patients. The aforementioned Swedish data could be useful in implying the extent of personal, health, and social problems that Kazakhstan's severely addicted patients face when serving their court treatment sentences.

Compared to developed countries where strict, restrictive approaches are combined with evidence-based interventions, Kazakhstan has focused on the implementation of psychosocial support only in the voluntary sector. To the best of our knowledge, there is no legal act or normative document establishing anything other than pharmacological interventions within compulsory treatment. The interviews with the experts displayed sporadic attempts to implement some elements of rehabilitation programmes: motivational counselling, psychoeducation, individual sessions with psychotherapists, peer support groups, art therapy, and structured leisure activities.

> When I worked at a compulsory treatment department, it was our duty (for doctors) to provide different kinds of psychotherapy. Every day I assembled my patients in a special room to hold various sessions. I brought for them paints for art therapy, prepared lectures about addictions and somatic diseases. Every now and then, they participated in trainings. Over the span of their terms, I did my best to motivate them to sustain sobriety after release. At first, it was quite a challenge with newcomers. After a while, my patients got used to attending group sessions. I understand now that those 'psychotherapy' interventions were implemented only thanks to our head doctor. [There were] no legal standards, only local initiatives, extrapolation from voluntary departments (Expert #2).

As mentioned above, relatives and concerned significant others play a key role in drug addiction treatment programmes. In this regard, interventions and supportive care for families in combination with direct patient-oriented measures should be considered as more comprehensive and effective anti-relapse services than those focusing only on patients. These practical observations remain pertinent even in the context of compulsory treatment.

The research data describing the isolation process during compulsory treatment from the patient's perspective underlined feelings of isolation and anxiety entailing emotional withdrawal, shame, and guilt (Petterson et al., 2021; Ridley & Hunter, 2013; Walker et al., 2018). The Swedish quantitative study by Berg et al. (2021) revealed that even among medical professionals, there was no consensus as to how the main principles of social contact enhancement could be implemented in practice.

The basic right of having the freedom to talk to contacts and concerned significant others was challenged by the restrictive rules of compulsory treatment. On the one hand, isolation was seen as necessary for the client's recovery process. On the other hand, relatives were essential motivators for patient compliancy, especially among resistant patients. Berg et al. (2021) discerned that the balance in this issue was mostly attributable to the expertise of the medical staff, which encompassed the ability to systematically evaluate patients and analyse their family systems, communicative resources, and social capital.

From the perspective of relatives, restrictive treatment conditions are mostly considered as the last opportunity for patients to overcome self-destructive behaviour and to reduce potential social and health risks. In the study by Silva et al. (2021), relatives' expectations regarding compulsory treatment were strikingly high, accompanied by the belief that the justice system was able to sensitise their loved ones to addiction and to mobilise their resources. In Kazakhstan, the role of relatives for compulsory treatment admissions is essential as their applications and calls are the main inclusion criteria for the initiation of the court processes. Therefore, the motivations, expectations, and extent of relatives' involvement are of the utmost relevance for patient pathways in compulsory programmes.

To the best of our knowledge, there was only one mention of relative attitudes towards compulsory treatment in local publications. According to Ibrayeva et al. (2014), half of the surveyed relatives evaluated the quality of drug addiction services negatively, while a third of them agreed with the relevance of compulsory options. The family members of compulsory treatment supporters were more likely to have a severe form of addictions (76%) with high rates of unsuccessful re-admittance episodes and resistance to rehabilitation.

The interviews with the experts disclosed that support care for relatives was not available on a systematic basis in their clinics.

> Relatives were able to control and monitor the courses of treatment of our patients. They had regular meetings with the heads of the departments. Unfortunately, those discussions were only formal information exchanges, clarifications about clinical symptoms. In our department [Pavlodar], there were not any special sessions with psychologists or psychotherapists for family members. On the other hand, we did not limit face-to-face contact between our patients and their relatives. The rule was only that their family relevance had to be confirmed with documents (marital certificates for husbands/wives, certificates of birth for parents and siblings) (Expert #1).

> In Semey, we did not have special regulations for working with relatives. That was the duty of our head. But in parallel, we informed them about our local initiative 'Visavi' – a community of parents and relatives involved in addictions. 'Visavi' held regular meetings in outpatient facilities and organised peer-supported groups with psychologists and psychotherapists (Expert #2).

Considering the lack of standards and requirements for psychosocial support within compulsory treatment, it could be implied that family-oriented care is beyond the scope of capacity building for the whole involuntary treatment sector in Kazakhstan. Fragmentary examples of care options for families are provided through NGOs or as part of anti-relapse procedures at the local level at particular regional clinics. To the best of our knowledge, this has not yet been adapted for the compulsory context.

According to case studies and expert information, social work is not represented in Kazakhstan's compulsory sector at the systemic level. Social work positions in compulsory departments are mostly organised for nurses to provide sporadic social services: help with ID regulations or other legal issues and counselling regarding vocational problems and social allowances. Meanwhile, the wide array of scientific literature and evidence-based policies underline the key role of social workers in the organisation and management of holistic treatment processes for addicted patients based on an ecological approach and case management principles (Wells et al., 2013).

The establishment of resourceful social networks with comprehensive assessment and planning are of the utmost importance, especially for those patients who suffer from severe forms of addictions and have had negative experiences with numerous treatment failures. In this regard, professionally trained social workers could provide interventions for the integration and resocialisation of patients over the span of a compulsory treatment term, utilising various interventions (motivational therapy, CBT, contingency management). In practice, the expert interviews revealed that social workers were not included in this evidence-based model. None of the experts was aware of internationally acknowledged competencies in social work with drug-addicted people while pointing out the principal role of clinical staff in compulsory treatment. However, the limited competencies in social counselling and the high caseload (up to 50 patients per doctor) do not allow doctors to provide balanced, accurate, and individual support for their patients.

Conclusions

This analysis of the compulsory drug treatment sector revealed a wide range of problems in service provision, among which the absence of evidence-based technologies is of the utmost concern. According to international research data, even involuntary conditions should be accompanied by psychoeducation, motivational counselling, CBT, and supportive family care. In Kazakhstan's compulsory treatment sector, some of these elements have been introduced in particular departments but without any supervision or systematic approach. Meanwhile, official statistical data cast doubt on the effectiveness of compulsory methods as a whole. The high readmittance rate indicates the need for major revisions of compulsory principles. The current countrywide mental health reforms aim to reduce the number of compulsory beds and transform them into psychosocial places for voluntary-admitted inpatients. However, the discussions and debates in Kazakhstan society, including in professional circles, prove that the drug treatment system is not ready to eliminate compulsory departments totally, taking into account the absence of other alternatives for severely addicted patients with aggressive and anti-social behaviour.

More attention should be paid to strengthening compulsory treatment programmes and developing evidence-based care that focuses not only on the reduction of the addiction symptoms but also on the well-being and social adaptation of patients and their families. Considering the high percentage of compulsory-treated patients, the involuntary facilities could be the starting point for motivational work and case management aimed at raising readiness and adherence to more comprehensive voluntary rehabilitation programmes. Moreover, the role of social workers at the compulsory treatment departments should be revised. It is impossible to actualise the topic of effective involuntary treatment without increasing access to evidence-based case-management models and patient reintegration into the community. All of these warrant increasing the relevance of social work for the multidisciplinary teams working in drug addiction treatment programmes, especially those with restrictive conditions.

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Overview of the conducted interviews

Expert#1, medical doctor, Pavlodar, 19 July 2022.
Expert#2, medical doctor, Pavlodar, 22 August 2022.
Expert#3, a chief analyst, Pavlodar, 29 August 2022.